State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2009 3. Time of Death 1. Decedent's Name (First, Middle, Last) December 8,2009 Month **Physician** 11:25 層 Barbara Ann Michael /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Anne Arundel Anne Arundel Medical Center Annapolis If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 10/27/1934 9. Birthplace (State or Foreign 7. Age (In vrs. last birthday) 5. Social Security Number 6. Sex **Funeral** Min. Months Days Hours 1 □ M 2√2 F 75 Washington DC 579-48-5790 **Director** Usual Residence of Decedent 10d. Inside City Limits filed within 72 hours after death with the Maryland 10c. City. Town or Location 10b. County 10a. State r than "natural", or items 23a or 28a-f show the Medical Evandment out to notified at 1 ☐ Yes 2 ☐ No Director Lothian MD Anne Arundel 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number 20711 USA 912 Lower Pindell Road Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 11 Marital Status 1 ☐ Never Married 2 ☐ Married Specify: White Baltimore, Maryland 21215-0036 1 ☐Yes 2 XNo Specify. þ 3 ☐ Widowed 4 🕅 Divorced Completed 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) College (1-4or 5+) Elementary/Secondary (0-12) nd Mental Hygiene. marked other than GPO Bookeeper 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) . Pages 1 and 2 should be file trainent of Health and Mental H tant: If item 27 Is marked oth Be Ruth Scheele Alfred T. Rowley 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) permit. Pages 1 and 2 s Department of Health ar Important: If item 27 is any injury or other trau 912 Lower Pindell Road Lothian, MD Karen Patton Daughter 20c. Location - City or Town, State 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 1 ☐ Burial 2 A Cremation 3 ☐ Removal from State 12/09/09 Glen Burnie,MD Atlantic Crematory 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility 21. Signature of Fune at Service Licensee 12 Ridgely Ave Annapolis, MD 21401 Hardesty Funeral Home P.A. Oats 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or hear failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final YLOUS **Physician** -mphyse ma disease or condition resulting in death) /Medical Due to (or as a conse uence of): **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examine that the death certificate be executed and Due to (or as a consequence of): burial-Box 68760, physician Physician/Medical the attending pl IF FEMALE 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 🗆 Ectopic pregnancy Month Day Year in the past 12 months? 1 ☐ Yes 2 KNo 4 ☐ Pregnant at time of death 5 ☐ Other (specify) signed by the a P.O. 9 DUnknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Division of Vital Records, \$ 1 X Yes 2 No 3 Probably 4 Unknown page 2 should Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has autopsy performed certificate 2 □ No 1 ☐ Yes 2 XNo 1 ☐ Yes funeral director, 25. Was case referred to medical 26. Place of Death (Check only one) Be examiner? Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1∐Yes 2KMNo 1 MInpatient 2 ☐ ER/Outpatient 3 ☐ DOA within 24 hours after death.

To the Funeral Director: After this completely filled in by the funeral dir Certification: To 28a. Date of Injury (Month, Day, Year) 28b. Time of 28d. Describe how injury occurred 27. Manner of Death 28c. Injury at Work? To the Hospital or Attending 5 ☐ Pending investigation 1 Natural 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be determined 3 🗌 Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical (Check only one) and manner stated. 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifier Jew Bech, MD 12/8/09 D46052 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Sjolval Beth, tho 2001 Medical Parkway annapolis, Mp 31. Date filed (Month, Day, Year) DEC 15 32. Registrar's Signature State 2009 Registrar

DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death Decedent's Name (First, Middle, Last) 2 Date of Death Physician/ DECEMBER PATRICIA ANITA MEADOWS 2009 5:07 A M Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City. Town, or Location of Death 4c. County of Death QUEEN ANNE'S HOSPICE OF OUEEN ANNE'S HOSPICE CENTER CENTREVILLE Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8 Date of Birth 9. Birthplace (State or Foreign **Funeral** 1 🗆 M 2 🗶 Months Director 65 DCTOBER 8.1944 MARYLAND 214-44-4373 Usual Residence of Decedent or than "natural", or items 23a or 28a-f show the Medical Examiner must be notified at 10a State 10b. County 10c, City, Town or Location 10d. Inside City Limits Director QUEEN ANNE'S STEVENSVILLE 1 Yes 2 X No 10e. Street and Number 10f. Zip Code 10g, Citizen of What Country? Funeral 21666 420 VICTORIA WAY USA hours after death 11. Marital Status 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. Armed Forces? ğ 1 Never Married 2 Married Maryland 21215-0036 If Yes, Give Year or Dates. 1 ☐ Yes 2 X No Specify: Completed 3 Widowed 4 Divorced WHITE 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) other than Elementary/Seconday (0-12) College (1-4 or 5+) 11 CAFETERIA MANAGER FOOD SERVICE Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) and Mental F ISABELL P. POTTER DONALD P. BEACH, SR. other traumatic permit. Page 1 and 2 should t Department of Health and Me Important: If item 27 is mark 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 420 VICTORIA WAY, STEVENSVILLE, MARYLAND 21666 CALVIN JAMES MEADOWS/HUSBAND Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State cemetery, crematory or other place)
CHESAPEAKE
CREMATION CENTER 1 Burial 2 X Cremation 3 Removal from State DECEMBER 18 injury or 4 Donation 5 Other (Specify) 2009 STEVENSVILLE, MARYLAND 2. Name and Address of Facility
ELLOWS, HELFENBEIN AND NEWNAM FUNERAL HOME, P.A.
06 SHAMROCK ROAD, CHESTER, MARYLAND 21619 21. Signature of Furferal Service Licenses 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause or each line. Approximate Interval Betweer Pulmona Immediate Cause (Final Onset and Death Pnysician, disease or condition resulting in death) Medical Due to (or as a consequence of) Examiner Sequentially list conditions, Examine if any, leading to in rediate cause. Enter Underlying Due to (or as a consequence or) The law requires that the death certificate be executed the burial-transi Cause (Disease or iinjury and that initiated events resulting in death) Last Due to (or as a consequence of): ending physician are use as the burial-Physician/Medical Division of Vital Records, P.O. Box 68760 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy 5 Other (specify) ____ in the past 12 months?

1 Yes 2 No
9 Unknown Day Pregnant at time of death signed by the at d be detached for Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 🗆 Yes 2 🗆 No 3 🗆 Probably 🔀 Unknown Completed should 24b. Were autopsy findings available prior to completion of cause of death? 24a, Was an autopsy performe certificate Yes 2 No 1 Yes 2 No To the Hospital or Attending Physician: 25. Was case referred to medical Certificate: To Be 26. Place of Death (Check only one) HOSPICE CENTER 1 Yes 2 No Other: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 4 Nursing Home 5 Residence this funeral 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 🔀 Natural 5 Pending iniury work? 1 ☐ Yes 2 ☐ No Accident Investigation filled in by the after deat Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined within 24 hours a

To the Funeral C

completed filled Medical 29a. Certifier 🖞 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check only one) 99 who completed cause of death (Item 23a) (Type, Print) VACERIE 2540 man 10,0

DHMH 17 Rev 7/2009

State Registrar 31. Date filed (Month, Day, Year)

32. Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Dav Physician/ 10:5 Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death 787 Springdale Drive Millersville Anne Arundel 9. Birthplace (State or Foreign Country) North Carolina 5. Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, **Funeral** 1 □ M 2 🔀 Days Min 89 Yrs. Director 212-16-8581 8/11/1920 28a-f show 10a. State 10b. County iral", or items 23a or 28a-f sho Examiner must be notified at 10c. City. Town or Location 10d. Inside City Limits Director Marvland Anne Arundel Annapolis 1 ☐ Yes 2 No 10e. Street and Number 10f, Zip Code 10g. Citizen of What Country? Funeral 711 Bon Haven Dr. 21401 USA filed within 72 hours after death 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 💢 No Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, ģ 1 Never Married 2 X Married ☐ Yes Yes, Give Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify: White Completed 3 Widowed 4 Divorced Year or Dates permit. Page 1 and 2 should be filed within 72 hour Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natu may injury or other traumatic event, the Medical. 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) Homemaker Home 7th Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) မ Jesse McCoin Etta Duncan 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Bonnie S. Forsythe/ Daughter 711 Bon Haven Dr., Annapolis, MD 21401 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place, Date 20c. Location - City or Town, State 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Hillcrest Cemetery 12/14/09 Annapolis, MD 21. Signature of Paperal Solvice Licensee 22. Name and Address of Facility George P. Kalas Funeral Home 2973 Solomons Island Rd. Edgewater, MD 21037 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between shock, or heart failure. List only one cause on each line Immediate Cause (Final Onset and Death Physician/ End stage dementia more than 6 mos.) Medical Examiner resulting in death) Due to (or as a consequence of) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examine Due to (or as a consequence of): nding physician and use as the burial-transit Cause (Disease or finjury that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical P.O. Box 68760 use as IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ____ To the Hospital or Attending Physician: The law requires that the death within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the atter completed filled in by the funeral director, page 2 should be detached for a in the past 12 months?
1 Yes 2 No Month Dav Year 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by Division of Vital Records, 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☑ Unknown 24b. Were autopsy findings available prior to completion of cause of 24a. Was an autopsy death? 2 X No 1 Yes 2 🔲 No Yes 25. Was case referred to medical Certificate: To Be 26. Place of Death (Check only one) examiner?
1 Yes 2 Yes Other 1 Inpatient 2 I ER/Outpatient 3 I DOA 4 Nursing Home 5 Residence 6 Other (Specify) 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 Natural 5 Pending work? Accident Investigation Suicide Could not be 28e. Piace of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined City or Town, State) Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier (Check 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29b. Signature And title of certific 29d. Date signed (Month. Day. Year) ie and address of person who completed bause of death (Item 23a) (Type, Prin

DHMH 17 Rev 7/2009

State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene for State Registrar Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Month 2 Day 5:01 Physician/ 20 Medical 4a. Facility Name (if not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death Examiner Prince George's Hyattsville 1909 Belle Haven Drive # 101 If Under 1 Year | If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** 09/18/1956 Mary Land 1 M 2 M Months 212-68-0751 Director Usual Residence of Decedent 10d. Inside City Limits permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event. 10b. County 10c. City. Town or Location 10a. State Director 1X Yes 2 No P.G. <u>Hyattsville</u> Md. 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code Funeral U.S.A. 20785 1909 Belle Haven Drive # 101 Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 12. Was Decedent Ever in U.S. 11. Marital Status Black, White, etc.
African-Armed Force 1 Yes 2 No 1 Never Married 2 Married ģ Baltimore, Maryland 21215-0036 1 ☐ Yes 2 K No Specify: American 3 Widowed 4 Divorced Completed Year or Dates 16a. Decedent's Usual Occupation 16b. Kind of Business Industry 15. Decedent's Education (Give kind of work done during most of working (Specify only highest grade completed) life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) Own Home Homemaker 12th Be 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Constance Elizabeth Jackson ျှ James Arthur Young 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Gode) 1909 Belle Haven Dr. # 101, Hyattsville, Md. 20785 19a. Informant's Name/Relationship (Type, Print) Lloyd McIntyre/Husband 20c. Location - City or Town, State 20b. Place of Disposition (Name of 20a. Method of Disposition Date 1 🖾 Burial 2 🗌 Cremation 3 🗆 Removal from State Harmony Mem. Park Landover, Maryland 12/26/09 4 Donation 5 Other (Specify) 21. Signature of Funeral Service Licens 22. Name and Address of Facility
H.S. Washington & Sons Co., Inc. any OV 5.1 als 4925 Burroughs Ave., N.E., Washington, D.C. 20019 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between shock, or heart failure. List only one cause on each Opset and Death Immediate Cause (Final disease or condition Physician/ Medical resulting in death) Due to (or as a consequence of): Examiner Sequentially list conditions if any leaching to in a class cause. Enter Underlying Examiner Due to lor as a conse quence of Hospital or Attending Physician: The law requires that the death certificate be executed attending physician and for use as the burial-transit Cause (Disease or linjury that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d, Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months?

1 Yes 2 No
9 Unknown Month Day Year Pregnant at time of death 5 Other (specify) After this certificate has been signed by the functional director, page 2 should be detached Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? <u>۾</u> 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a, Was an autopsy performed?
Yes 2 N 1 ☐ Yes 2 ☐ No within 24 hours after death.

To the Funeral Director. After this certifics completed filled in by the funeral director, to 26. Place of Death (Check only one) Be 25. Was case referred to medical examiner? Other: 2 3 မ 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) 28a. Date of injury (Month, Day, Year) 28c. Injury at work? 27. Manner of Death 28b. Time of 28d. Describe how injury occurred Certificate: 5 Pending 1 Natura 1 Yes 2 No 2 Accident
3 Suicide Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined Medical 1 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier (Check and the time, date and place, and due to the cause(s) and manner as stated only one) 29d. Date signed (Month 29b. Signature and title of certifier Name and address of person who State

Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar 42505 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month LaVern Κ. McDona1d 2009 1310 December 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Anne Arundel Crofton Care and Rehabilitation Crofton 5. Social Security Number 9. Birthplace (State or Foreign 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth 1 □ M 2 🗹 🗸 Days Hours Min. (Month, Day, Year 217-32-1235 1933 Kansas Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Maryland Prince George's Bowie 1¥XYes 2 □ No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? U.S.A. 20715 2502 Kittery Lane 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14. Race - American Indian 11. Marital Status Armed Forces?

1 Yes 2 KNo Black White etc. 1 Never Married 2 Married 1 Yes 2 No Specify: If Yes, Give Year or Dates White 3 Xidowed 4 Divorced Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) State Government State Investigator 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Elnora Barbara Ricke George Henry Traffas 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 2502 Kittery Lane, Bowie, Maryland 20715 Karen Bobby- Daughter 20a. Method of Disposition 20b. Place of Disposition (Name of Date 20c. Location - City or Town, State 1 ₺ Burial 2 ☐ Cremation 3 ☐ Removal from State westend Cemetery 12/29/2009 Stephenville, Texas 4 Donation 5 Other (Specify) Signature of Funeral Service Licensee Robert E. Evans Funeral Home 22. Name and Address of Facility You 1. Koul 16000 Annapolis Road, Bowie, Maryland 20715 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Betweer

Physician/ Medical Examiner

Physician/

Medical

Examiner

Funeral

Director

or 28a-f show notified at

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and Mental Hygiene. 'is marked other than "natural", or items 23a or raumatic event, the Medical Examiner must be r

permit. Page 1 and 2 should be fi Department of Health and Menta Important: If item 27 is marked any injury or other traumatic ev

should be filed within 72 hours after death and Mental Hygiene.

Baltimore, Maryland 21215-0036

Director

Funeral

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Completed

Be

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the Maryland

with 1

burial-1 attending physician for use as the burial Physician/Medical the signed by t I be detach To Be Completed by within 24 hours after death.

To the Funeral Director, After of completed filled in by the funeri Certificate:

To the Hospital or Attending Physician: The law requires that the death certificate be executed

Division of Vital Records, P.O. Box 68760

	Immediate Cause (Final disease or condition resulting in death)	a. Advicinud dementia Due to (or as a consequence of):		Onset and Death
ical Examiner	if any, leading to immediate cause. Enter Underlying Cause (Disease or linjury that initiated events resulting in death) Last	b. Due to (or as a consequence of):		
Completed by Physician/Medical	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 Yes 2 No 9 Unknown	23c. If yes, outcome of pregnancy 1	23d. Date of de Month	elivery Day Year
pleted by Pł	Part II. Other significant conditions	ontributing to death but not resulting in the underlying cause given in Part I.	23e. Did tobacco use contribute to 1 Yes 2 No 3 F 24a. Was an autopsy 24b. Were au prior to	
			performed? death?	s 2 No
To Be	25. Was case referred to medical examiner? 1 ☐ Yes 2 No	26. Place of Death (Check of Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 ★ Nursing Home	nly one) $= 5 \square$ Residence $6 \square$ Other (Spec	cify)
	27. Manner of Death 1 Natural 5 Pending 2 Accident Investigation	28a. Date of injury (Month, Day, Year) 28b. Time of injury 28c. Injury at work? 1 ☐ Yes 2 ☐ No	d. Describe how injury occurred	
Medical Certificate:	3 Suicide 6 Could not l 4 Homicide determined	28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)	f. Location (Street and Number or Ru City or Town, State)	ıral Route Number,
Medica	(Check 2 Medical Exam	sician: To the best of my knowledge, death occurred at the time, date and place, and o iner: On the basis of examination and/or investigation, in my opinion, death occurred at the se Practioner: To the best of my knowledge, death occurred at the time, date and place,	e time, date and place, and due to the	cause(s) and manner state

29c. License number

146251

State Registrar 29b. Signature and title of certifier

(Item 23a) (Type, Print)

1 - For State Registrar

		•	For State Registrar	Otato of me	,	Certificate of	Death	R	eg. No. 2	009	42506
o	Physicia	an	1. Decedent's Name (First, Middle	, Last)				2. Date of Dear Month	Day	Year	3. Time of Death
	/Medic		Avery Nelso	o, Sr.				12	9	2009	147JM
	Examin	er	4a. Facility Name (If not institution		and ker		or Location of Death		4c. Cou	nty of Death	ia
	Funeral		Ten/nsuln Key/ow. 5. Social Security Number		e (In yrs. last birth	nday) If Under 1 Year	If Under 24 Hrs.	8. Date of Birth	1	9. Birthp	lace (State or Foreign
	Director		216-56-0519	¹¼M 2□F 57	Υ	rs. Months Days	Hours Min.	(Month, Day		MD	ntry)
	D .		Usual Residence of Decedent 10a. State 10b. County		10c. City, Town	or Location				1	0d. Inside City Limits
	raryia F shor	ō			,						1 □ Yes 2 📉 No
	28a-1	Director	MD Worce 10e. Street and Number	ester	Pocomo	10f, Zip Code			0g. Citizen	of What Cour	ntry?
3	is 1 and 2 should be filed within 72 hours after death with the maryland of Health and Mental Hygiene. 18 Health and Mental Hygiene. 19 Health and Hygiene. 19 Health and Hygiene.		1304 Buck Ha	rbor Road		21851			U.S.A	۸.	
:	oms 2	Funeral	11. Marital Status	12. Was Decedent B Armed Forces?	Ever in U.S.	13. Was Decedent of If Yes, specify Cut	Hispanic Origin? (Sp			Race - Americ	
9	or ite		1 ☐ Never Married 2 【 Marri		No rinca	1 □Yes 2 X No		7 1110411, 0101,			
Maryland 21215-0036	ural",	d b	3 Widowed 4 Divorced			Decedent's Usual Occu	unation			ecify: Black f Buşiness/In	dustry
2	2/ III	Completed	15. Decedent (Specify only highes	t grade completed)		(Give kind of work done life. DO NOT use retire	during most of world		Worce	ster	Co
212	r thai	l lig	Elementary/Secondary (0-12) 1 2	College (1-4or 5		rectiona	l Office	er	Deter	ition	Ctr.
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X a	should be rand Mental I s marked of umatic eve	2	Rollie Nelso	n			Ella Ma				
la l	2 sho h and 7 Is ma tr aum		19a. Informant's Name/Relationsh			Mailing Address (Stree					
မ ်	Tand 2 Health em 27 I		Sheila Nelso 20a. Method of Disposition	n/Wife	20b Place of	04 Buck H	arbor Ro	Date		MD 21 on - City or To	
5	0		1 Surial 2 Cremation		cemeter)	Disposition (Name of , crematory or other pla	Cem				
altimore,	그두쭈륵		4 ☐ Donation 5 ☐ Other (Sp. 21. Signature of Funeral Service I		TINGI	ey's Chap 22. Name and Addr Bennie S	ress of Facility 0.1	7 17 7	Pocc	moke,	MD
ñ	Depar Impor any Ir		Lund	Fort		Bennie S Funeral	mith 91	lisbur	v. Mr	2180	1
			23a. Part 1. Enter the disease, or shock, or heart failure. List			ot enter the mode of dy	ing, such as cardiac	or respiratory ar	rest,		Approximate Interval Between
	hysician		Immediate Cause (Final disease or condition	mULTI S	YSTEM	ORGAN 1): 1): 1): 1): 1): 1): 1): 1):	FAILURE	=			Onset and Death
	/Medical Examiner		resulting in death)	Due to (or as	a consequence o	f):					
	-xammer	7	Sequentially list conditions,	b. Due to (or as	MEC	ACOCON					
	nsit	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	CLOST.	RIDIA	DIFFIC	KE IN	IFELT 10	N		
Ć,	exectin and ial-tra	Exa	that initiated events resulting in death) Last	C	a consequence o						
68760	rancate be executed ng physician and as the burial-transit	Medical	8	d							
			IF FEMALE:								
Вох	attendii for use	ian/	23b. Was decedent pregnant in the past 12 months?		2 Fetal death	3 Ectopic pregnar	ncy		23d.	Date of deliv Month	ery Day Year
P.O.	The taw requires that the death ce ate has been signed by the attendi bage 2 should be detached for use	Physician/	1 ☐ Yes 2 ☐ No 9 ☐ Unknown	4 ☐ Pregnant a 9 ☐ Unknown	t time of death	5 ☐ Other (specify)					
σ.	v requires that the or been signed by the should be detached		Part II. Other significant condition	ns contributing to death b	ut not resulting in	the underlying cause g	iven in Part I.	23e. Did to	bacco use	contribute to t	he cause of death?
Division of Vital Records,	quires an sign uld be	ed by	ATHEROSCLEL	OTIC CARPI	OVASCU	LLAR PIS	EASE.	1 🗆 Y	es 2□N	lo 3□ Pro	bably 4 Munknown
၀ ၁	has bee e 2 sho	Completed						24a. Was a		4b. Were auto	opsy findings available ompletion of cause of
ž į	ate ha	E O						perfor		death? 1 ☐ Yes	
ita	clan: ertific ector,	Be (25. Was case referred to medical examiner?					th (Check only o	ne)		
0	rnysi this o		1 ☐ Yes 2 No 27. Manner of Death	Hospital: 1 Inpatie		patient 3 DOA		ome 5 Resid			fy)
u .	After funer	tion	1 Natural 5 ☐ Pending		ıry 28b. T y, Yea <i>r)</i> Ir	ijury Wa	uryat ork? ⊒Yes 2™MNo	28d. Describe h	low injury oc	curred	
ISI.	Atten r deat octor: by the	fica	3 ☐ Suicide 6 ☐ Could r	not be 28e. Place of Injuried		m, street, factory, office				umber or Rut	al Route Number,
	al or a after il Dire	Certification: To	4 ☐ Homicide determ	building, etc	c. (Specify)			City or Tou	n, State)		
	lospir I hour unera	edical (g Physician: To the best Examiner: On the basis o							
Ţ,	or the host atter death. within 24 hours after death. To the Funeral Director: After this certificate he completely filled in by the funeral director, page	Medi	one)	and manner sta						gned (Month	
_	\$ \$ ₹ €		29b. Signature and title of certifier	L Ogbun	e and		nse number			19/09	
	24111		30. Name and address of person	who completed cause of	leath (Item 23a) (Type, Print)	34593			1/-/	
	J. Dr.		Nicholas Oo	burn. m.D	PRMC.	IDO E C	arroll et	Salis	bury	mD=	11801
	Sta	te	30. Name and address of person Nicholas Oq 31. Date filed (Month Day Year)	32. Pegistr	ar's Signature	1			//		<u>~</u>
	Registr	ar	050 13	CUUS /CHA	m B.	gan					

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Month **Physician** Decembe Tony Leon Oliver /Medical 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) Examiner Medica Plata la Birthplace (State or Foreign Country) If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, 5. Social Security Number 6. Sex 7. Age (In vrs. last birthday) Year) **Funeral** Days Min. Months Hours 1☑ M 2□ F 76 Yrs January18,1933 Maryland Director 213-30-9325 Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 10a. State 10b. County 7 is marked other than "natural", or items 23a or 28a-f show traumatic event, Ire Medical Examinar must be notified at toryes 2 □ No Funeral Director Charles MD Bel Alton 10g. Citizen of What Country? 10f. Zip Code 10e Street and Number US 20609 8880 Fairgrounds Road 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 1★ Yes 2 □ No If Yes, Give Year or Dates: 1955 14. Race - American Indian Black, White, etc. 11. Marital Status filed within 72 hours after 1 ☐ Never Married 2 ☐ Married 1 ☐ Yes 2 ☑ No Specify: White Baltimore, Maryland 21215-0036 þ 3 Widowed 4 Divorced Completed 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) permit. Pages 1 and 2 should be filed within Department of Health and Mental Hygiene. Important: If item 27 is marked other than "any injury or other traumatic event, Ins Mex College (1-4or 5+) Elementary/Secondary (0-12) Truck Driver 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Louise Tippett ပ Asbury Oliver 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) \$6697 Hummingbird Ct.Mechanicsville, MD 20659 Catherine Carpenter/Sister 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Nation 3 ☐ Removal from State MD Veterans' Cemetery 12/21/09 Cheltenham, MD 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility 21. Signature of Funeral Service Licensee MOOS 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Physician Or /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last to (or Examine 010 certificate be executed and burial-trar Due to (or as a consequence of): attending physician for use as the burial Box 68760, Physician/Medical IF FEMALE 23c. If yes, outcome of pregnancy

1 Live birth 2 Fetal death
4 Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy • Hospital or Attending Physician: The law requires that the death 24 hours after death. • Funeral Director: After this certificate has been signed by the atter Month Day in the past 12 months? 5 Other (specify) □Yes 2□No signed by the 6 d be detached for P.O. 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Division of Vital Records, þ 1 ☐ Yes 2 ☐ No 3 ☐ Frobably 4 ☐ Unknown icate has been significate page 2 should b Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed 212 No 2 🗆 No 1 □ Yes 26. Place of Death (Check only one) 25. Was case referred to medical Be examiner? 1☐ res 2☐ No Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To 28b. Time of 28d. Describe how injury occurred 28a. Date of Injury (Month, Day, Year) 28c. Injury at Work? 27. Manner of Death Injury 1 Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident filled in by the 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 6 ☐ Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 Suicide determined 4 Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical 29a. Certifier 2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one)

within 2 To the I Free

State Registrar

29c. License number

29d. Date signed (Month, Day, Year)

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

29b. Signature and title of certifier

SAH DE VAD WALDORF 20602 Old WASHINGTON RD, SUITE 202, 3450 PRADIP 32. Registrar's Signature 31. Date filed (Month, Day, Year)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ December 12,2009° Donald Wilson Proctor 9:00A M Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** 1127 Simsbury Court Anne Arundel Crofton 5. Social Security Number If Under 1 Year If Under 24 Hrs. Age (In yrs. last birthday) 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** . Ди 2 □ г Days Months Hours Min. 62 Washington DC Director 214-48-5355 Usual Residence of Decedent ral", or items 23a or 28a-f shov Examiner must be notified at 10b. County 10a, State 10c. City, Town or Location 10d. Inside City Limits Director MD Anne Arundel Crofton 1 Yes 2 No 10e. Street and Number 10f, Zip Code 10g, Citizen of What Country? Funeral **IISA** 1127 Simsbury Ct. 21114 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 12. Was Decedent Ever in U.S. 14. Race - American Indian Armed Forces Black, White, etc. 2 □ No Vietnam Completed by 1 Never Married 2 Married X Yes Maryland 21215-0036 White 1 ☐ Yes 2 X No Specify If Yes, Give "natural", 3 Widowed 4 XXDivorced Year or Dates the Medical 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) permit. Page 1 and 2 should be filed within 72 Department of Health and Mental Hygiene. Important: If item 27 is marked other than any injury or other traumatic event, the Men Elementary/Seconday (0-12) College (1-4 or 5+) 12 Auto Parts Delivery 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Herman Wilson Proctor Carvel Gibbons 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Elkridge, MD Kevin Proctor Irwin Way Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 1 Burial 2 X Cremation 3 Removal from State 4 Donation 5 Other (Specify) 12/15/2009 Glen Burnie, MD Atlantic Crematory 21. Signature of Tuneral Service Licensee 22. Name and Address of Facility Hardesty Funeral Home, P.A. 4 Annapolis, MD 21401 12 Ridgely Ave. 23a. Part 1. Enter the disease, or complications that caused shock, or heart failure. List only one cause on each line. or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between Onset and Death Immediate Cause (Final TROKE Pnysician/ Medical resulting in death) Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Due to (or as a conseq Exami that the death certificate be executed HYPERLIPIDEMIN that initiated events resulting in death) Last Due to (or as a consequence of) attending physician for use as the burlal-Physician/Medical Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery Ectopic pregnancy in the past 12 months? Month Pregnant at time of death 5 Other (specify) signed by the a d be detached f Yes 2 No 9 Unknown 9 Unknown P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Þ Division of Vital Records, Hospital or Attending Physician; The law requires Completed 1 🗌 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of 24a. Was an has autopsy performed? 2 No 2 🗹 No 1 🗌 Yes Be 25. Was case referred to medical 26. Place of Death (Check only one) examiner? 1 \(\text{Yes} 2 1 No Other: 4 \square Nursing Home 5 Residence 6 \square Other (Specify) ည 1 Inpatient 2 I ER/Outpatient 3 I DOA this 27. Manner of Death 28a. Date of injury (Month, Day, Year) Certificate: 28b. Time of 28c. Injury at 28d. Describe how injury occurred After 1 Natural 5 Pending work? Investigation
6 Could not be 1 ☐ Yes 2 ☐ No within 24 hours after death

To the Funeral Director. /
completed filled in by the i Accident 3 Suicide 4 Homicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined

54

Medical

29a. Certifier

only one)

29b. Signature and title of certifier

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

AL. VOLLANKI. 8850, COLY MBIA N. VellAnking 31. Date filed (Month, Day, Year) 32. Registrar's Signature

DEC 15

PARKWAY 100

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated

30469

29d. Date signed (Month, Day, Year)

MD. 21045

29c. License number

Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene) \(\) Certificate of Death 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) 6:30 A M **Physician** /Medical 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) **Examiner** Anne Arundel Gambrills Regency Park Assisted Living Birthplace (State or Foreign Country) If Under 1 Year | If Under 24 Hrs. 7. Age (In vrs. last birthday, 8. Date of Birth (Month, Day, Social Security Number 6. Sex Year) **Funeral** NY NY 1 M 2□ F Months Days Hours 8/17/1924 85 101-16-2225 Director Usual Residence of Decedent 10d. Inside City Limits Pages 1 and 2 should be filed within 72 hours after death with the Maryland 10c. City, Town or Location 10b. County r 28a-f show 10a. State 1 ☐ Yes 🏋 No Gambrills MD Anne Arundel Directo 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number permit. Pages 1 and 2 should be filed within 72 hours after death with 1 Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "natural", or Items 23a or is any Injury or other traumatic event, the Medical Examinat must be none. 21054 USA 615 Florida Place Funeral 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 11. Marital Status 1 Never Married 2 Married White Baltimore, Maryland 21215-0036 1 □Yes 2\No If Yes, Give Year or Dates Specify: Specify: þ 3 Widowed 4 Divorced Completed 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) College (1-4or 5+) Elementary/Secondary (0-12) Brokerage Real Estate 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Edna Mae Winters Earl Eugene Patterson P 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) Gambrills, MD 21054 615 Florida Place Helen Patterson Spouse 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20a. Method of Disposition **XX**Burial 2 ☐ Cremation 3 ☐ Removal from State Glen Haven Cemetery 12/16/2009 Glen Burnie, MD 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility Hardesty Funeral Home, P.A. 21. Signature of Funeral Service License Annapolis, MD 21401 Vals 12 Ridgely Ave. 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each fine. Approximate Interval Between Onset and Death Immediate Cause (Final 760 mws **Physician** resulting in death) /Medical Due to (or as a consequence of): Examiner >6 mos Sequentially list conditions, cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examine the Hospital or Attending Physician: The law requires that the death certificate be executed ling physician and e as the burial-trans Due to (or as a consequence of) Division of Vital Records, P.O. Box 68760, Physician/Medical signed by the attending | | be detached for use as IF FEMALE: yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months? 1 Live birth 2 Fetal death 3 Ectopic pregnancy Month Day Year 5 Other (specify) ☐Yes 2☐No 9 Unknown 9 ☐ Unknown signed by 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Completed by 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has autopsy perforn To the Hospital or Attending ruyawan. within 24 hours after death.

To the Funeral Director: After this certificate! completely filled in by the funeral director, pag 2 2 No 1 🗆 Yes 1 □ Yes 26. Place of Death (Check only one) Be 25. Was case referred to medical Other: 4 ☐ Nursing Home 5 ☐ Residence 6 ☑ Other (Specify) 2 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 1 ☐ Yes Certification: To 28a. Date of Injury (Month, Day, Year) 28c. Injury at Work? 28b. Time of 28d. Describe how injury occurred 27. Manner of Death Injury 5 ☐ Pending investigation 1 Matural 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 Suicide determined 4 ☐ Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Medical 29a. Certifier 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifier

State Registrar

iox.

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

32. Registrar's Signature

DEC

Year) 15

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 2009 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month Marvin Edward Page December 2009 12:30 Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City. Town, or Location of Death 4c. County of Death Anne Arundel Medical Center Anne Arundel Annapolis Social Security Number 6. Sex 1 Å M 2 □ If Under 1 Year If Under 24 Hrs. 7. Age (In vrs. last birthday Funeral 8. Date of Birth 9. Birthplace (State or Foreign Hours 4/15/1934 Washington, DC Director 577-44-3643 75 Usual Residence of Decedent or 28a-f shov 10a. State 10b. County or than "natural", or items 23a or 28a-f sho the Medical Examiner must be notified at 10c. City. Town or Location 10d. Inside City Limits Director 1 Yes 2 No Maryland | Anne Arundel Lothian 10e. Street and Number 10f. Zip Code 10g, Citizen of What Country? Funeral 55 Edward Lane 20711 USA filed within 72 hours after death 11 Marital Status 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Armed Forces? Black, White, etc. 1 Never Married 2 Married þ Maryland 21215-0036 1 ☐ Yes 2X No Specify: 3 X Widowed 4 Divorced Specify: Completed Year or Dates White 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) and Mental Hygiene. is marked other than Elementary/Seconday (0-12) College (1-4 or 5+) 12th Telephone Company Lineman Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Department of Health and Ment. Important: If item 27 is marken any injury or *** David Page Genevieve Boswell 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Patricia S. Kauffman/ Daughter 3902 Woodhaven Lane, Bowie, MD 20715 Baltimore, 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 Burial 2 X Cremation 3 Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Kalas Crematory 12/15/09 Edgewater, Maryland 21. Signatur Fu eral S Lic see 22. Name and Address of Facility George P. Kalas Funeral Home 2973 Solomons Island Rd. Edgewater, 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause one each line. Immediate Cause (Final SWING POTH Physician/ LOBI disease or condition Medical resulting in death) Due to (or as a consequence of): Examiner Sequentially list conditions, Examine If any, leading to introducts cause. Enter Underlying Cause (Disease or iinjury that initiated events Due to for as a consequence on burial-transit Due to (or as a consequence of): resulting in death) Last attending physician for use as the buria Physician/Medical To the Hospital or Attending Physician: The law requires that the death certificate be Division of Vital Records, P.O. Box 68760 IF FEMALE 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? Day Year Pregnant at time of death 5 Other (specify) 2 No the g Unknown 9 Unknown signed by tl Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 2 No 1 🗌 Yes 3 Probably 4 Unknown Completed s been si 24b. Were autopsy findings available prior to completion of cause of death?

1
Yes 2 24a. Was an has autopsy performed? Yes 2 page 2 within 24 hours after death.

To the Funeral Director; After this certificate I completed filled in by the funeral director, page 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Other: IN PATION မ 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Spe HOSPICE 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred Natural injury 5 Pending Accident
Suicide 1 Yes 2 🗌 No Investigation 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

State

Registrar

DHMH 17 Rev 7/2009

(Check

only one 29b. Signature

Year)

se of death (Item 83a) (Type, Print)

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

State of Maryland / Department of Health and Mental Hygiene 2009 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Harry Carlton Parrott, Jr. **Physician** DEC. 2009 24, 09:52 PM /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City. Town, or Location of Death **Examiner** 101 Dorchester 218 Meteor Ave., Apt. Cambridge 8. Date of Birth
July 21,1925 If Under 1 Year | If Under 24 Hrs. 9. Birthplace (State or Foreign 5. Social Security Number 6 Sex 7. Age (In vrs. last birthday) **Funeral** Days Hours Min. NOKM 2□ F Mary Tand 84 218-20-3618 Director Usual Residence of Decedent 10d. Inside City Limits 10a. State 10b. County 10c. City. Town or Location 28a-f show item 27 is marked other than "natural", or items 23a or 28a-f show other traumatic event, the Medical Examents and the Livillia of Cambridge MD Dorchester 1¥ Yes 2 □ No Director 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 21613 218 Meteor Ave., Apt. 101 United States Pages 1 and 2 should be filed within 72 hours after death went of Health and Mental Hygiene. Int: If item 27 is marked other than "natural", or items 23. Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ∰Yes 2 ☐ No If Yes, Give Year or Dates: 1 4 3 - 4 6 14. Race - American Indian, Black, White, etc. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 1 Never Married 2000 Narried Specify: White Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☐ No Specify. Completed by 3 Widowed 4 Divorced 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Upholstery Upho1sterer 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Lottie Rhea Harry C. Parrott, ပ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State Zip Code) $218\,$ Meteor Ave., Apt. 101, Cambridge, MD $_{216}$ 19a. Informant's Name/Relationship (Type. Print) Bertie W. Parrott/Spouse 21613 20b. Place of Disposition (Name of cemetery, cromatory or other place Junior Urder Cem. Date 20c. Location - City or Town, State 20a. Method of Disposition permit. Pages 1
Department of H
Important: If ite
any Injury or ot Preston, Maryland 12/29/09 1X Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility Framptom Funeral nome 216 N. Main St., Federalsburg, MD 21632 F.A. 21. Signature of Funeral Service Licensee Approximate Interval Between Onset and Death 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) LUNG METASTASIS **Physician** < 11 MONTHS /Medical Due to (or as a consequence of) Examiner MACGNAUT Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examine Due to for as a consequence of the death certificate be executed attending physician and for use as the burial-tran Due to (or as a consequence of): P.O. Box 68760, Physician/Medical 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months? 3 Ectopic pregnancy 4 Pregnant at time of death 5 Other (specify) ☐Yes 2☐No 9 Unknown signed by t 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Division of Vital Records, HELLI TUS 2 🗹 No 3 Probably 4 Unknown 1 ☐ Yes Completed peen 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has performe this certificate 1 ☐ Yes 2 ☑ No 1 ☐ Yes 2 ☐ No To the Hospital or Attending Physician: within 24 hours after death.

To the Funeral Director: After this certifica completely filled in by the funeral director, p 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No Certification: To 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of 28d. Describe how injury occurred 28c. Injury at Work? 5 Pending investigation 1 Natural 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 3 🗌 Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 🗌 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

| Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier (Check only one) and manner stated. 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 00058662 30. Name and oddress of person who completed cause of death (Item 23a) (Type, Print) OUTHATION 7 31. Date filed (Month, Day, Year) State DEC 29 2009 Registrar

ORIGINAL

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) 28 **Physician** December 2009 2010 Lona L. Petty /Medical 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) Examiner Cecil 367 South Simpers Road Elkton Birthplace (State or Foreign Country) 8. Date of Birth (Month, Day, June 27, If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** Months Days Hours 1 □ M 2 🗓 F Yrs 1940 Delaware 69 **Director** 217-64-1504 Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 10a. State 10b. County show item 27 is marked other than "natural", or items 23a or 28a-f show other traumatic event, the Modical Examinar invest be routthed at 1 ☐Yes 2 No Director Maryland Ceci1 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number permit. Pages 1 and 2 should be filed within 72 hours after death with Department of Health and Mental Hygiene. Important: if them 27 is marked other than "natural" -- " any injury or other traumatic parts." United States 367 South Simpers Road 21921 Funeral 14. Race - American Indian Black, White, etc. 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 1 ∐Yes 2 X No If Yes, Give Year or Dates: 1 ☐ Never Married 2 ☐ Married 1 ☐ Yes 2 X No Specify: þ White 3 Widowed 4 X Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) College (1-4or 5+) Elementary/Secondary (0-12) In Her Own Home Homemaker 11 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Gertrude I. Louge Arthur A. Veal 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 56-110 Welsh Tract Road, Newark, DE 19713 Robyn L. Akins/Daughter 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) Date December 31, 2009 Union Cemetery Union. MD 4 Donation 5 ☐ Other (Specify) 22. Name and Address of Facility Hicks Home for Funerals, P.A. 103 W. Stockton Street, Elkton, 21. Signature of Funeral Service Licensee 21921 Approximate Interval Between Onset and Death 23a. Part 1 Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final **Physician** disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examine Hospital or Attending Physiclan: The law requires that the death certificate be executed 24 hours after death.
Funeral Director: After this certificate has been signed by the attending physician and sate has been signed by the attending physician and page 2 should be detached for use as the burial-transi Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760 Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant 1 ☐ Live birth 2 ☐ Fetal death 4 ☐ Pregnant at time of death in the past 12 months? 3 Ectopic pregnancy Month Day Year 5 Other (specify) 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 2 2 X No 3 Probably 4 Unknown 1 🗌 Yes Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? 1 Yes 2 No 2 X No 1 🗌 Yes filled in by the funeral director, 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Tes 2 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To 28b. Time of 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural 2 Accident 5 Pending investigation 1 ☐ Yes 2 ☐ No 6 ☐ Could not be 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical 29a. Certifier 1/A Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) (Check only one) and manner stated. within 2 To the 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 29c. License number

State Registrar

DHMH 17 Rev 1/2001

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

32. Registraris Signatu

		For State	State	of Marylan		rtment of F	Health and	Mental Hy	-	0000	1.2513
		Registrar 1. Decedent's Name (First, Midd	fle (act)		Cer	uncate of	Deaiii —	2. Date of De	Reg. No.	2003	4 2 3 1 3 3. Time of Death
Physicia	ın	Hazel M.						Month	Day		
/Medic	_	4a. Facility Name (If not institution				4b. City. Town, o	r Location of Deat	Dec_	4c.	2009 County of Death	12:08 PM
Examin	er				D	•			""	Talbo	.+
Funeral		Genesis Hea 5. Social Security Number	6. Sex	- The 7. Age (In yrs.	Pines last birthday)	If Under 1 Year	ston If Under 24 Hrs	8. Date of Bi	rth	9. Birth	place (State or Foreign
Director		219-07-7625	1 □ M 2 🗓 F	8	6 Yrs.	Months Days	Hours Min.	Sept.	10,	1923 Mar	yland
ō	- 1	Usual Residence of Decedent									
rylan show	- 1	10a. State 10b. County	•	10c. Cit	ty, Town or Lo						10d. Inside City Limits
e Ma Ba-f s	Director		oline		F 6	ederals	burg				1 ☐ Yes 2 🙀 No
ith th		10e. Street and Number	_			10f. Zip Code				zen of What Cou	
ath w		5780 Jester					1632			ted St	
be filed within 72 hours after death with the Maryland tal Hygiene. tal Hygiene. d other than "natural", or items 23a or 28a-f show event, the Medical Evaning must be notified at	Funeral	11. Marital Status	Armed F		.S. 13. V	Vas Decedent of I fYes, specify Cub	lispanic Origin? (S an, Mexican, Puer	Specify Yes or N to Rican, etc.)	0-	 Race - Ameri Black, White, 	
s affe	by F	1 ☐ Never Married 2 ☐ Mar 3 ☑ Widowed 4 ☐ Divorce	If Yes, G	2 No ive		□Yes 2 X No	Specify:			Specify: W	hite
hour tural	ed	A	nt's Education	Jales.	16a. Deced	lent's Usual Occup	pation		16b. Ki	nd of Business/Ir	ndustry
in 72 n "na	Completed	(Specify only highe	est grade completed)		(Give	kind of work done OO NOT use retire	during most of word)	rking			,
with giene r tha	mo	Elementary/Secondary (0-12) 11 (Grad.)	College ((1-4or 5+)	Home	emaker			Ow	n Home	
filed I Hyg other	Bec	17. Father's Name (First, Middle					18. Mother's Nar	me (First, Middle	e, Maiden	Surname)	
fenta fenta rked tlc ev	<u>유</u>	Vernon Ott	co Wrigh	t			Lois	Annie	Shu	felt	
shou and N s man	-	19a. Informant's Name/Relation	ship (Type. Print)		19b. Mailin	g Address (Street	and Number or R	ural Route Numi	ber, City o	r Town, State, Zi	p Code)
alth alth artra		Judy Morse/I	Daughter		8050	N. For	rk Blvd	., Eas	ton,	MD 21	601
other other		20a. Method of Disposition		20b. F		sition (Name of natory or other pla		Date		ocation - City or T	
Page nent c nt: If		1 → Burial 2 ☐ Cremation 4 ☐ Donation 5 ☐ Other (State B1c	omery	Cemetery		28/09	Smi	thvil1	e, MD
permit. Pages 1 and 2 should be filed within 72 hours. Department of Health and Mental Hygiene. Important: If Hem 27 is marked other than "natural", any injury or other traumatic event, the Medical Eva once.		21. Signature of Funeral Service			I .	. Name and Addre	I .	rampto	m Fu	neral 1	Home
		Vilmay	t. Usti	ou			n St., F		100	g, MD 21	-
		23a. Part 1. Enter the disease, of shock, or heart failure. Lis	r complications that t only one cause on	caused the deat each line.	h. Do not ente	er the mode of dyi	ng, such as cardia	c or respiratory	arrest,		Approximate Interval Between Onset and Death
Physician	1	Immediate Cause (Final disease or condition	a	TO DS	15						deys
/Medical Examiner		resulting in death)	Due to	(or as a conseq	juence of):		, .				
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ted 1sit	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events	₹ Due to	(or as a conseq	juence oi).						
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requires that the death certific seen signed by the attending p hould be detached for use as:	Physician/Me	IF FEMALE: 23b. Was decedent pregnant	23c. If yes, or	utcome of pregna	ancy					23d. Date of deli	/er v
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in: T		25. Was case referred to medica	al				26. Place of De			1 □ Yes	2 🗆 No
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g Phy er thi		27. Manner of Death	28a. Date	of Injury nth, Day, Year)	28b. Time of			28d. Describe			
ath. F.: Aft	aţio	1 Natural 5 Pendi 2 Accident invest	ing (Moi tigation	ntn, Day, rear)	Injury		k?]Yes 2 ☐ No				
Atte or deg ector by th	ific	3 ☐ Suicide 6 ☐ Could	I not be 28e. Plac	e of Injury - At h	ome, farm, stre	eet, factory, office		28f. Location	(Street ar	nd Number or Ru	ral Route Number,
al or	Certification: To	4 Hornicide	bullo	ing, etc. (Speci	(4)			City of 10	own, State	*)	
To the Hospital or Attending Physician: The law within 24 hours after death. To the Funeral Director. After this certificate has completely filled in by the funeral director, page 2 s	edical (ing Physician: To the								
the hin 24	ledi	one)	and ma	nner stated.							
5 viii	Σ	29b. Signature and title of certific	200	3 M2	>	29c. Licen	se number		29d. Da	te signed (Month	, Day, Year)
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		30. Name and address of person		. /			Q., ~	ERS	That	mr.	21001
		KOBERT SAN 31. Date filed (Month, Day, Year	NCHES W			Dremit	11146-	~175	ruv,	1 11) 0	χ1φ01
Sta Registra		DEC 23 2	009	Registrar's Sign	Sau	Kel					
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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month 12 Day/O Physician/ Year 205 7:10 AM Eugene Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death Southern Maryland Hospital Clinton George Prince 5. Social Security Number If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** 1 M 2 □ E Days Hours Min. 9 - 3 - 19, 4°8 Director 216-50-8234 61 Washington DC Usual Residence of Decedent fshow 10a. State 10b. County 10c. City, Town or Location filed within 72 hours after death with the Maryland ral", or items 23a or 28a-f sho Examiner must be notified at 10d. Inside City Limits Director 1 X Yes 2 No MarylandPrince George Brandywine 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral USA 12607 Martin Rd 20613 12. Was Decedent Ever in U.S Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian Black, White, etc. 1 Never Married 2 Married þ 1 XYes 2 No If Yes, Give 1974 Year or Dates. Maryland 21215-0036 1 ☐ Yes 2 No Specify: Specify:Black "natural", 3 Widowed 4 Divorced Completed the Medical 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) and Mental Hygiene. Elementary/Seconday (0-12) College (1-4 or 5+) 12 State Department Specialist 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) pe Daniel E. Ragsdale Sr Evelyn Simpson 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Page 1 and 2 sh Department of Health a Important: If item 27 is any injury or other tra Rocquel Martin / Daughter 2500 St.S.E.Apt.1, Washington DC 20019 N Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place, Date 1 🗓 Burial 2 □ Cremation 3 □ Removal from State MD Veterans 4 ☐ Donation 5 ☐ Other (Specify) 12/21/2009 Cheltenham, MD 21. Signature of Funeral Service Licenses 22. Name and Address of Facility 7/00 Adams Funeral Home Pa, Aquasco MD MO1589 20608 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician DAT disease or condition Medical resulting in death) Due to (or a a consequence of) Examiner um bog Sequentially list conditions, if any, reading to immediate cause. Enter Underlying Examine Due to for as a consequence of Cause (Disease or linjury that initiated events and Due to (or as a consequence of) resulting in death) Last -purialwel physician ast 1 Physician/Medical Physician: The law requires that the death certificate be Box 68760 the attending IF FEMALE: use 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy
5 Other (specify) ____ ò in the past 12 mg Month Pregnant at time of death 1 Yes 2 Unknown ed by the a P.O. signed to Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by Division of Vital Records, 1 Tes 2 No 3 Probably 4 Unknown peen Were autopsy findings available prior to completion of cause of 24a. Was an 1 has autopsy perform death? 24 hours fler death. Funeral Director After this certificate 1 ☐ Yes 2 ☐ No 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? 1 Tes မူ 2(X)No Other: Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) 27. Manner of Death 28a. Date of injury 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred Hospital or Attending (Month, Day, Year) Natural 5 Pending work' 1 🗌 Yes 2 Accident
3 Suicide
4 Homicide Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by determined

within 24 hours Medical the Registrar DHMH 17 Rev 7/2009

29a. Certifier

29b. Signature

30. Name and 50

(Check

only one

and title of certifi

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31. Date filed (Month, Day, Year)

Akim

2009

address of person who completed cause of death (Item 23a) (Type, Print)

20,00

istrar's Signature

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1 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

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Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

			State of Maryland / Dep.	artment of Health and N <i>rtificate of Death</i>	0.0	00 10515
			Registrar 1. Decedent's Name (First, Middle, Last)	Tillicate of Death	Reg. No. 2. Date of Death	3. Time of Death
	Physicia	an	Robert Stodghill			Year 8: 20 PM
	/Medic Examin		4a. Facility Name (If not institution, give street and number)	4b. City, Town, or Location of Death	4c. County o	
	LXaIIIII	G1	Future Care Chesapeake	Arnold	Anne A	rundel
	Funeral Director		5. Social Security Number 6. Sex 7. Age (In yrs. last birthday, $212-64-0539$ 1 2 3 4 2 2 5 5 5 5 5	If Under 1 Year If Under 24 Hrs. Months Days Hours Min.	(Month, Day, Year)	9. Birthplace (State or Foreign Country) MD
	p	ļ	Usual Residence of Decedent 10a State 10b, County 10c. City, Town or L.	and in a		10d. Inside City Limits
	show	5				1 □Yes 2 XNo
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	with t		1103 St. Stephens Church Road	21032	USA	,
	ns 23	Funeral Director	-	Was Decedent of Hispanic Origin? (Sp If Yes, specify Cuban, Mexican, Puerto		- American Indian,
5-0036	be filed within 72 hours after death with the Maryland rial Hygiene. d othey than "natural", or items 23a or 28a-f show event, the Medical Evan in the file of the country of the medical Evan in the medical	Š	Armed Forces? 1 ☐ Never Married 2 Married	If Yes, specify Cuban, Mexican, Puerto 1 □Yes 2 ♥ No Specify:	Specify:	, White, etc. White
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<u>X</u>	2 should be f and Mental I is marked o raumatic eve	2	Robert Chievoos Stodghill JR.		rene Jones	21.4. 27. (0.41)
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altimore,	permit. Pages 1 and 2 should be Department of Health and Mental Important: If item 27 is marked any injury or other traumatic evone.		11 Burial 2 & Cremation 3 Hemoval from State	matory or other place)	20c. Location - C 4/09 Glen Bu	City or Town, State
Balt	permit. Departi Importi any Inj		21. Signature of Fuperal Service Idensee	2. Name and Address of Facility Hardesty Funeral H	lome P.A. Gambri	napolis ₂ Read IIs,MD 21054
A Salaria	Physician /Medical		23a. Part 1. Enter the disease, or complications that caused the death. Do not en shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Due to (or as a conseq ence of):	Acicyosis	or respiratory arrest,	Approximate Interval Between Onset and Death
	Examiner	iner	Sequentially list conditions, if any, leading to immediate educ. Either Underthing Cause (Disease or injury			
,00,	eath certificate be executed attending physician and for use as the burial-transit	al Examiner	that initiated events resulting in death) Last C Due to (or as a consequence of):			
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7.	law requires that the dias seen signed by the 2 should be detached	þ	Part II. Other significant conditions contributing to death but not resulting in the	underlying cause given in Part I.	110.7	ibute to the cause of death? 3 ☐ Probably 4 ☐ Unknown
Ö	requ	etec	- Trappade -		24a. Was an 24b. V	Vere autopsy findings available
Vital Records,	he lay ate has p. ge 2	Completed			autopsy p	rior to completion of cause of eath? □Yes 2□No
<u> </u>	Attending Physician: The r death. ector: After this certificate by the funeral director, peg	Be	25. Was case referred to medical examiner? Hospital: Hospital:	Othor: 3	th (Check only one)	
0	Phys r this ral dir	7: To	27. Manner of Death 28a. Date of Injury 28b. Time	of 28c. Injury at	lome 5 ☐ Residence 6 ☐ Othe 28d. Describe how injury occurre	
_	ading Ph th. : After th : funeral	tion	1 Matural 5 Pending (Month, Day, Year) Injury 2 Accident investigation	Work? M 1 □ Yes 2 □ No		
DIVISION	I or Atter after dea Director I in by the	ertification:	3 ☐ Suicide 4 ☐ Homicide 6 ☐ Could not be determined 28e. Place of Injury - At home, farm, so building, etc. (Specify)	treet, factory, office	28f. Location (Street and Number City or Town, State)	er or Rural Route Number,
	To the Hospital or Attendin within 24 hours after death. To the Funeral Director: Aft completely filled in by the fun	ledical C	29a. Certifier (Check only one) 1 Certifying Physician: To the best of my knowledge, dering the desired form one one) 1 Medical Examiner: On the basis of examination and/or and manner stated.	ath occurred at the time, date and place investigation, in my opinion, death occu	l e, and due to the cause(s) and ma urred at the time, date and place, a	nner as stated. and due to the cause(s)
	To th within To th	Me	29b. Signature and title of certifier	29c. License number	_	(Month, Day, Year)
			Manici ms	D57531	Decem	by 14, 2009
	: 0		30. Name and address of person who completed cause of death (Item 23a) (Type			by 14, 2009
	1 (1)		mobile New Box 8601 Vetering the	sy Juste 204	millerfulle	80,15 cm
	Sta Registr		31. Date filed (Month, Day Year) 32. Registrar's Signature DEC 15 2009	barles		

	-	For State	State of Maryland / Dep	ertificate of Death		Reg. No. 2009	42516
		Registrar 1. Decedent's Name (First, Middle, La			2. Date of Dea	ıth	3. Time of Death
Physicia		Toledo	Smith		Month 12	17 O9	3:10 a ^M
/Medic Examin	er	4a. Facility Name (If not institution, giv		4b. City, Town, or Location of Death	1	4c. County of Deat	
Funeral Director		5. Social Security Number 6. S 246-40-9699	Sex 7. Age (In yrs. last birthda 77 Yrs.	y) If Under 1 Year If Under 24 Hrs. Months Days Hours Min.	8. Date of Birtl 04-30-1	∠ Year) Co	hplace (State or Foreign untry) ginia
		Usual Residence of Decedent					10d. Inside City Limits
e Marylar ba-f show	ctor	10a. State 10b. County PG	10c. City, Town or	Clintor			YQYes 2□No
th with the 23a or 28 and be no	Funeral Director	10e. Street and Number 8600 Mike Shapiro	Dr. #914	10f. Zip Code 20735		10g. Citizen of What Co	•
permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Department of Health and Mental Hygiene. Department of Health and Mental Hygiene. The mortant: If item 27 Is marked other than "natural", or items 23a or 28a-f show any Injury or other traumatic event, I've Medical Evan in an unit to notified at once.	þ	11. Marital Status 1 ☐ Never Married 2 ☑ Married 3 ☐ Widowed 4 ☐ Divorced	12. Was Decedent Ever in U.S. Armed Forces? 1	 Was Decedent of Hispanic Origin? (S If Yes, specify Cuban, Mexican, Puert □ Yes 2\infty No Specify: 	pecify Yes or No- o Rican, etc.)	14. Race - Ame Black, White Specifolace	e, etc.
thin 72 ho ne. nan "natur Medical	Completed	15. Decedent's E (Specify only highest grade) (Specify only highest grade)	ade completed) (Gi	cedent's Usual Occupation we kind of work done during most of wor . DO NOT use retired)	king	16b. Kind of Business/	Industry
ed wi		4		tenance Engineer	(First Middle	Private	
ould be fill Mental H arked oth atic even	To Be	17. Father's Name (First, Middle, Last OSCAT	Smith	Emma	Smit		
and 2 sho satth and 27 Is mi er traums		19a. Informant's Name/Relationship Thomasine Smith/		illing Address (Street and Number or Ru Mike Shapiro Dr.			
Pages 1 alent of He nt: If item		20a. Method of Disposition 1 Burial 2 □ Cremation 3 □ 4 □ Donation 5 □ Other (Speci	Removal from State Glenwood	position (Name of rematory or other place) 1. Cemetery 12-2	Date 23–09	20c. Location - City or Washington	
permit. Departm Importa any Inju		21. Signature of Funeral Service Lice	nsee	22. Name and Address of Facility Ror 0583 Middleport Lr	-		20695
		shock, or heart failure. List only	polications that caused the death. Do not				Approximate Interval Between Onset and Death
Physician /Medical		Immediate Cause (Final disease or condition resulting in death)	a Septicemia				
Examiner		1	Due to (or as a consequence of):				
	_	On accounting the link and dikings	, Yeast Bacteremia				
	a l	Sequentially list conditions, if any leading to immediate	Due to (or as a consequence of):				
nsit	mine	if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	Due to (or as a consequence of):				
be executed sician and burial-transit	al Examiner	if any, leading to immediate cause. Enter Underlying	Due to (or as a consequence of): C Due to (or as a consequence of):				
ficate be executed physician and is the burial-transit	dical	if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events	C				
he death certificate be executed the attending physician and shed for use as the burial-transit	dical	if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events	c	3 □ Ectopic pregnancy 5 □ Other (specify)		23d. Date of de Month	livery Day Year
ires that the death certificate be executed signed by the attending physician and the detached for use as the burial-transit.	by Physician/Medical	if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 Yes 2 No 9 Unknown	c	5 Other (specify)		Month obacco use contribute t	Day Year
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. The law requires that the death certificate be executed cate has been signed by the attending physician and page 2 should be detached for use as the burial-transit.	Physician/Medical	if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1	c	5 Other (specify)	1 🗆 ¹	Month obacco use contribute t Yes 2 ☑ No 3 ☐ F an osy prior to death?	Day Year o the cause of death?
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Physician: The law requires that the death certificate be executed this certificate has been signed by the attending physician and al director, page 2 should be detached for use as the burial-transit.	To Be Completed by Physician/Medical	if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown Part II. Other significant conditions Acute Renal Fail 25. Was case referred to medical examiner? 1 □ Yes 2 □ No	C	26. Place of Detection 3 DOA Other: 4 Nursing F	24a. Was autor performent of the control of the con	Month obacco use contribute t Yes 2 N No 3 P an sy 24b. Were a prior to death? 2 N No 1 Ye. one) dence 6 Other (Spa	Day Year o the cause of death? robably 4 Unknown utopsy findings available completion of cause of
tending Physician. The law requires that the death certificate be executed leath. tor: After this certificate has been signed by the attending physician and the funeral director, page 2 should be detached for use as the burial-transit.	To Be Completed by Physician/Medical	if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 Yes 2 No 9 Unknown Part ii. Other significant conditions Acute Renal Fail 25. Was case referred to medical examiner? 1 Yes 2 No 27. Manner of Death 1 Natural 5 Pending investigation	Due to (or as a consequence of): d. 23c. If yes, outcome of pregnancy 1	26. Place of Detection tient 3 DOA Other: 4 Nursing Base of Y	24a. Was autop perfo 1 Tyes ath (Check only conditions 5 Resident 28d. Describe I	Month obacco use contribute to the contribute t	Day Year o the cause of death? robably 4 □ Unknown utopsy findings available completion of cause of s 2 □ XNo
trai or Attending Physician. The law requires that the death certificate be executed tra after death. Is after death. In Director, After this certificate has been signed by the attending physician and led in by the funeral director, page 2 should be detached for use as the burial-transit.	Be Completed by Physician/Medical	if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 Yes 2 No 9 Unknown Part II. Other significant conditions Acute Renal Fail 25. Was case referred to medical examiner? 1 Yes 2 No 27. Manner of Death 1 Natural 5 Pending	Due to (or as a consequence of): d. 23c. If yes, outcome of pregnancy 1	26. Place of Detection tient 3 DOA Other: 4 Nursing Base of Y	24a. Was autop perfo 1 Tyes ath (Check only conditions 5 Resident 28d. Describe I	Month obacco use contribute t Yes 2 N No 3 P an 24b. Were a prior to death? 2 No 1 Ye. one) dence 6 Other (Spathow injury occurred	Day Year o the cause of death? robably 4 □ Unknown utopsy findings available completion of cause of s 2 □ XNo
To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 burus after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit.	To Be Completed by Physician/Medical	if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1	Due to (or as a consequence of): d. 23c. If yes, outcome of pregnancy 1	26. Place of Decition 1 3 DOA Other: 4 Nursing Hard Y Work? M 1 Yes 2 No street, factory, office	24a. Was autop perfor 1 Tyes ath (Check only continues 5 Residues 28d. Describe 1 28f. Location (City or Total)	Month obacco use contribute to the second s	Day Year o the cause of death? robably 4 Unknown utopsy findings available completion of cause of s 2 Mio

State Registrar

Baltimore, Maryland 21215-0036

Division of Vital Records, P.O. Box 68760,

Richard Palmer M.D. 1328 Southern Ave. SE Suite 310 Washington DC 20032

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

31. Date filed (Month, Day, Year)
DEC 2 4 2009

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Alice Christine Smith 2009 2:48 P.M.M December 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death Prince George's Hospital Center Cheverly Prince George's If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) 02/20/1940 Birthplace (State or Foreign Country) Months Days Hours 1 □ M 2**X** F 69 Wash., D.C. 577-56-1849 Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10a. State D.C. Washington 1√Yes 2 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 20019 3300 East Capitol St., N.E. # A U.S.A. 12. Was Decedent Ever in U.S Armed Forces? 1 ☐ Yes 2 No 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 ☐ Never Married 2 ☐ Married African-If Yes, Give Year or Dates: 1∐Yes 2ŽNo 3X Widowed 4 ☐ Divorced American 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) 10th Housekeeper Hotels 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Evelyn Jones Gordon Savoy 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 11325 Marlee Avenue, Clinton, Maryland 20735 Michele Cousins/Daughter 20c. Location - City or Town, State 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 1 XBurial 2 ☐ Cremation 3 ☐ Removal from State 4 Donation 5 Dother (Specify) Harmony Mem. Park 12/30/09 Landover, Maryland 22. Name and Address of Facility ton & Sons Co., Inc. 4925 Burroughs Ave., N.E., Washington, D.C. 20019 21. Signature of Funeral Service Licenses 5.sau 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Fatal arrythmia Due to (or as a consequence of). ongestive Heart Failure Sequentially list conditions, if any, leading to inititediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Due to (or as a consequence of): IF FEMALE: 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 4 Pregnant at time of death 23d. Date of delivery 3 🗆 Ectopic pregnancy Month Day Year 5 ☐ Other (specify) 1 ☐ Yes 2 🔀 No Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performe 1 ☐ Yes 2 No 1 ☐ Yes 2 ☐ No 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 X No 1 ☑ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 27. Manner of Death

Physician /Medical Examiner

Physician

/Medical

Examiner

Funeral

Director

28a-f show

Director

Funeral

<u>გ</u>

Completed

Be

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ir than "natural", or items 23a or 28a-f sho the Medical Examiner must be notified at

Pages 1 and 2 should be filed within 72 hours after

permit. Pages 1 and 2 should be filed within Department of Health and Mental Hygiene. Important: If Item 27 is marked other than any injury or other traumatic event, I'm Mangones.

Baltimore, Maryland 21215-0036

cate has been signed by the attending physician and page 2 should be detached for use as the burial-transit Physician/Medical Completed by director, Be Certification: To After To the Hospital or Attendir within 24 hours after death.

To the Funeral Director: At completely filled in by the fur death.

The law requires that the death certificate be executed

P.O. Box 68760,

Division of Vital Records,

23b. Was decedent pregnant in the past 12 months? 9 I Unknown

and manner stated.

1 Natural

2 Accident

4 Homicide

3 Suicide

29a. Certifier

5 ☐ Pending investigation 6 ☐ Could not be determined

28b. Time of 28a. Date of Injury (Month, Day, Year)

Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28c. Injury at Work?

1 ី Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28f. Location (Street and Number or Rural Route Number, City or Town, State)

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29b. Signature and title of certifier

29c. License number

D-55770

29d. Date signed (Month, Day, Year)

who completed cause of death (Item 23a) (Type, Print)

3001 HOSPITAIDE CHEVERLY MD20785 Mati

State Registrar

Medical

31. Date filed (Month, Day, Year)
DEC 2 4 2009

State of Maryland / Department of Health and Mental Hygiens, Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month **Physician** 10: 26 PM 2009 20 sernice /Medical 4c. County of Death 4a. Fecility Name (If not institution, give street and number, 4b. City, Town, or Location of Death Examiner Anne Arundel County Assisted Living Annapolitan Annapolis If Under 1 Year If Under 24 Hrs. Months Days Hours Min. 8. Date of Birth (Month, Day, Year) 5. Social Security Number 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** 1 □ M 2 KF 574307253 1936 North Carolina Director Usual Residence of Decedent 10b. County 10c. City, Town or Location 10d. Inside City Limits * Phow 10a. State ral', or items 23a or 28a-f shov Examiner must be notified at 1x Yes 2 □ No Director DC Washington 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 1617 Trinidad Avenue, NE 20002 U.S.A. Funerai 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. Black, White, etc. 1 Yes 2 XNo
If Yes, Give
Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify: Specify: Black þ 3 XWidowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) 12th Examiner Bureau of Engraving 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ages 1 and 2 should be fit out of Health and Mental Hit: If Item 27 is marked oth Coley Ola Mae Doughtery Adolph 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 7287 Wood Hollow Terr., Ft. Washington, Md. 20744 Sheila R. Grose - Niece 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Date 20a. Method of Disposition 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State 4 □ Donation 5 □ Other (Specify) Lincoln Memorial Cem. 12-29-2009 Suitland, Maryland 22. Name and Address of Facility Ronald Taylor II Funeral Home 21. Signature of Funeral Service Licentee 10583 Middleport Lane, White Plains, Md. 20695 23a. Part1. Enter the disease, or complications but caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one caus on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Cardiac Physician 6 minutes /Medical Due to (or as a consequence of) Artery Disease Examiner years oronary Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner death certificate be executed physicien and the burial-tr Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, Physician/Medical anding pure IF FEMALE: 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months?

1 Yes 2 No 3 Ectopic pregnancy Month Year 4 Pregnant at time of death 5 Other (specify) been signed by the should be detached 9 Unknown 9 Unknow Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? b Vascular Dementia Yes 2 No 3 Probably 4 Unknown Completed Thoracic Vertebral Compression 24a. Was an autopsy performe 24b. Were autopsy findings available prior to completion of cause of death?

1 □ Yes 2 ☒ No has e 2 Osteoporasis 1 Yes 25. Was case referred to medical examiner? Assisted Be 26. Place of Death | Check only one Hospital: 1 | Inpatient Other: 4 Nursing Home 5 Residence 6 Other (Specify) LIVING 1 ☐ Yes 2 No Certification: To 2 ER/Outpatient 3 DOA 28a. Date of Injury (Month, Day Year) 28d. Describe how injury occurred 27. Manner of Death 28b. Time of 28c. Injury at Work? 1 Natural 2 Accident 5 Pending 1 ☐ Yes 2 ☐ No investigation 6 Could not be determined 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 | Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

[Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical (Check only 29b. Signature and title D0032654 30. Name and odd ass V person who completed cause of death (Item 23a) (Type, Print) 2033 Penderbrooke Dr Crownsville, MD relemits as mo State Registrar

DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Month 2009 Martha Scott Decembe: 6:45 Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Southern Maryland Hospital Clinton Prince Georges If Under Year If Under 24 Hrs. 8. Date of Birth Social Security Number 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign **Funeral** 1 □ M 2**X** F 08-29-1924 Months Days Hours Min Maryland Director 85 579-32-9733 Usual Residence of Decedent or 28a-f show notified at 10a. State 10b. County 10c. City. Town or Location 10d, Inside City Limits Director Md Prince Georges Suitland 1X Yes 2 ☐ No 10e. Street and Number 10f. Zip Code ò 10g. Citizen of What Country? ed other than "natural", or items 23a o event, the Medical Examiner must be Funeral 4811 Bennett Avenue 20746 U.S.A. permit. Page 1 and 2 should be filed within 72 hours after death Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items any injury or other traumatic event, the Medical Examiner mi Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14. Race - American Indian, 11. Marital Status Armed Forces?
1 ☐ Yes 2 X No Black, White, etc. 1 Never Married 2 Married þ Baltimore, Maryland 21215-0036 1 Yes 2 X No Specify: Black If Yes, Give 3X Widowed 4 □ Divorced Completed Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) C Nurse General Hospital Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ည John Smith Ida Gross 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Russeline Kyle - Daughter 4811 Bennett Avenue, Suitland, Maryland 20746 20a. Method of Disposition
1 ★ Burial 2 ☐ Cremation 3 ☐ Removal from State 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Date 4 ☐ Donation 5 ☐ Other (Specify) Ft. Lincoln Cemetery 12-30-2009 Brentwood, Maryland 21. Signature of Funeral Service License 22. Name and Address of Facility Ronald Taylor II Funeral Home 10583 Middleport Lane, White Plains, 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician. disease or condition resulting in death) Medical Due to (or as a consequence of) Examiner Sequentially list conditions. if any, leading to immediate cause. Enter Underlying Cause (Disease or linjury the Hospital or Attending Physician; The law requires that the death certificate be executed physician and sthe burial-trans that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical Box 68760 y the attending ph IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery ☐ Ectopic pregnancy in the past 12 months?

1 Yes 2 No
9 Unknown Pregnant at time of death Other (specify) 9 Unknown P.O. þ signed t Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 Yes 2 No 3 Probably 4 Unknown been sig Completed 24b. Were autopsy findings available prior to completion of cause of 24a. Was an has page 2: autopsy perform certificate 2 X No 1 Tyes Yes 25. Was case referred to medical Be 26. Place of Death (Check only one) 1 Yes Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 🗌 No မ 1 Inpatient 2 KER/Outpatient 3 I DOA this 24 hours after death.
Funeral Director: After thi 28a. Date of injury (Month, Day, Year) Certificate: 27. Manner of Death 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 Natural 5 Pending 1 Tyes Investigation 6 Could not be Accident

Division of Vital Records,

State Registrar

Medical

29b. Signature and (itle of certif

Suicide ☐ Homicide

29a. Certifier

(Check

0

of person who completed cause of death (Item 23a) (Type, Print)

determined

within 24 ho

To the Fune

completed fi

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

12 🔾 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

critiving Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29d. Date signed (Month, Day, Year)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death Reg. No. 2 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Month Marvin F Smith Jr 0553 M Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death SALISBUN. WIUMICO If Under 1 Year | If Under 24 Hrs/ 8. Date of Birth (Month, Day, Year) Sept 4, 1947 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign Funeral **1**√ M 2 □ F Days 224-66-1901 62 Mississippi Yrs Director Usual Residence of Decedent 28a-f shov 10b. County er than "natural", or items 23a or 28a-f sho the Medical Examiner must be notified at 10a State 10c. City, Town or Location 10d. Inside City Limits Director MD Wicomico Salisbury 1 X Yes 2 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 1017 Adams Ave., Apt E 21804 12. Was Decedent Ever in U.S. Armed Forces? 1 Yes 2 X No Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. ģ 1 Never Married 2 Married If Yes, Give Year or Dates 1 Yes 2 X No Specify White Completed 3 Widowed 4 X Divorced Specify: 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) should be filed within 72 and Mental Hygiene. Elementary/Seconday (0-12) College (1-4 or 5+) Disable 9th None injury or other traumatic event, Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) permit. Page 1 and 2 should be Department of Health and Menta Important: If item 27 is marked any injury or contract. ပ Marvin F Smith Sr Annie Mae Duncan Mahan 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 30299 Holly Lane, Delmar, MD 21875 Marjorie Vreeland 20a. Method of Disposition
1 □ Burial 2 ☐ Cremation 3 □ Removal from State 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State First State Cremation 12/28/09 4 Donation 5 Other (Specify) Millsboro, DE Signature of Funeral Service Licensee 22. Name and Address of Facility
Rogers Funeral Home Inc 23a. Part 1. Enter the disease, or complications that a used the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ disease or condition Medical resulting in death) Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Due to (or as a consequence of) Examin and -transit that the death certificate be executed Cause (Disease or linjury that initiated events Due to (or as a consequence of) resulting in death) Last physician a Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death
9 ☐ Unknown 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ____ in the past 12 months?
1 ☐ Yes 2 ☐ No ed by the 9 Unknown signed by be det Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ₽ Hospital or Attending Physician: The law requires 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 W Unknown Completed Were autopsy findings available prior to completion of cause of 24a. Was an page 2 s autopsy death? After this certificate 2 X No 1 Yes 2 No 1 Yes 25. Was case referred to medical Be 26. Place of Death (Check only one) Other: 1 Yes 2 12 No ည 1 M Inpatient 2 -ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) 27. Manner of Death 28a. Date of injury (Month, Day, Year) Certificate: 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 X Natural n 24 hours after death. e Funeral Director: Afte bleted filled in by the fur 5 Pending work? 1 ☐ Yes Accident Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 28f. Location (Street and Number or Rural Route Number, determined City or Town, State) Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier completed within 2 To the I 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated only one 29b. Signature and the of certifie 29d. Date signed (Month, Day, Year) 12/21/09 H5049)

Registrar DHMH 17 Rev 7/2009

State

31. Date filed

Baltimore, Maryland 21215-0036

Box 68760

P.O.

Records,

Division of Vital

amill

32. Registrar's Sigasture

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Snyder

State of Maryland / Department of Health and Mental Hygiene 2 1 1 9

			State of Maryland / De State of Maryland / De Registrar	partment of Health and N ertificate of Death	Mental Hygiene 2	009 42521
	Physici		1. Decedent's Name (First, Middle, Last) Earnest Reeves Testerman		2. Date of Death 12-18-2009	3. Time of Death 0454 A M
1	/Medic Examin		4a. Facility Name (If not institution, give street and number) 346 Nicholson Lane	4b. City, Town, or Location of Death	4c. Cour Bas	nty of Death よれのたと
	Funeral Director		5. Social Security Number 2.19-2.2-9806 6. Sex 1 □ N 2 □ F 83 Yrs	Monthel Dave Hours Min	8. Date of Birth	9. Birthplace (State or Foreign Country) Visign V.C.
e, Marylan	s 1 and 2 should be filed within 72 hours after death with the Maryland of Health and Mental Hygiene. Item 77 is marked other than "natural", or items 23a or 28a-f show other traumatic event, Its Madical Exemination at the notified at	To Be Completed by Funeral Director	Armed Forces? 1 Never Married 2 Married 1 Armed Forces? 1 Armed Forces. 1 Armed Forces? 1 Armed Forces.	10f. Zip Code 21078 3. Was Decedent of Hispanic Origin? (Spif Yes, specify Cuban, Mexican, Puerto 1 Yes 2 No Specify: seedent's Usual Occupation ive kind of work done during most of work e. DO NOT use retired) 18. Mother's Nam Minuse k ailing Address (Street and Number or Run Micholson: Lanc Es	Date United United Italian etc.) 14. R Specific Rican, etc.) 16b. Kind of Rican Surn. Italian Route Number, City or Towns Sex. House Cation 20c. Location	vn, State, Zip Code) 21221 n - City or Town, State
9	bermit. Pages 1 an Department of Heal Management of Heal Important; if then 2 any injury or other 2000.		23a. Part 1. Enter the disease, or complications that caused the death. Do not shock, or heart failure. List only one cadse on each line. Immediate Cause (Final disease or condition resulting in death) Due to (or as a consequence of):	22. Name and Address of Facility Zell 123 S. Ucshington Senter the mode of dying, such as cardiac	Unan Funeral St. Havre de	Home, P.A. 21078 Grace, Herryland Approximate Interval Between Onset and Death
O. Box 68760,	he death certificate be executed the attending physician and shed for use as the burial-transit	Physician/Medical Examiner	Se uentially list conditions if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 Yes 2 No 9 Unknown	3 Ectopic pregnancy 5 Other (specify)		Date of delivery Month Day Year
Division of Vital Records, P.	To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit	Certification: To Be Completed by Phy	Part II. Other significant conditions contributing to death but not resulting in the search of the s	26. Place of Dea 26. Place of Dea atient 3 □ DOA Other: 4 □ Nursing H te of Work? M 1 □ Yes 2 □ No	1 Yes 2 No. 24a. Was an autopsy performed? 1 Yes 2 No. th (Check only one) ome 5 Residence 6 No.	b. Were autopsy findings available prior to completion of cause of death? 1 □Yes 2 □No Other (Specify) So:1 3 home
Divi	To the Hospital or Attent within 24 hours after deall To the Funeral Director: completely filled in by the	Medical Certifi	4 Homicide determined 29a. Certifier (Check only 29a. Certifier	death occurred at the time, date and place or investigation, in my opinion, death occurred. 29c. License number	City or Town, State) e, and due to the cause(s) and urred at the time, date and play	d manner as stated. ce, and due to the cause(s)
	Sta Regist	ate rar	31. Date filed (Month, Day Year) 32. Registrar's Signature	paste	,	

State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) December 21, 2009 **Physician** 15:20 M THOMPSON MARGUERITA ELAINE /Medical 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) Examiner Montgomery Adventist Hospital Takoma Park Washington | If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth | Months | Days | Hours | Min. | O1 (Month Day) Birthplace (State or Foreign Country) 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) **Funeral** 1 □ M 2 🛣 F Wash. DC 579-42-6359 Director Usual Residence of Decedent permit. Pages 1 and 2 should be filled within 72 hours after death with the Maryland Department of Health and Mehtal Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Mecken Examines recovers once. 10d. Inside City Limits 10a. State 10b. County 10c. City, Town or Location 1x Yes 2 □ No Prince George's Hvattsville Maryland Director 10g. Citizen of What Country? 10f. Zip Code 10e Street and Number USA 20781 5805 42nd Avenue #420 Funeral Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14 Bace - American Indian. 12. Was Decedent Ever in U.S Armed Forces? 11. Marital Status 1 ☐ Yes 2X No If Yes, Give Year or Dates: 1 ☐ Never Married 2 ☐ Married Specify: Black 1 ☐ Yes 2 🕅 No Specify 2 3 X Widowed 4 Divorced Completed 16b. Kind of Business/Industry 16a Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Receptionist Private 12 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be (Simmons Emma Robert Α. Lucas ၉ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) Cipriano Rd., Lanham, MD 20706 Sandra Thompson, Daughter 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State 12/29/2009 Brentwood, MD Ft. Lincoln 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Payleral Service Ligentee 22. Name and Address of Facility Jordan Funeral Service, Inc. 4001 Benning Rd., NE, Washington, DC 20019 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only me cause on each line. Onset and Death Immediate Cause (Final **Physician** SEPTICAEMIA disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner MULTIPLE DECUBITI Sequentially list conditions, Examiner Due to for as a consequence of cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Hospital or Attending Physician: The law requires that the death certificate be executed and burial-tran Due to (or as a consequence of) Division of Vital Records, P.O. Box 68760, attending physician for use as the buria Physician/Medical 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Month Day Year in the past 12 months? 5 ☐ Other (specify) 1 ∐Yes 2**X** No the 9 Unknown 9 Unknown 23e Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. ð END STAGE RENAL DISEASE ON DIALYSIS 1 ☐ Yes 2 No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? LUPUS has autopsy performed certificate ANEMIA 1 ☐ Yes 2 ☐ No 1 ☐ Yes 2 🗓 No 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 \sum Nursing Home 5 \sum Residence 6 \subseteq Other (Specify) 1 Yes 2 No 1 K Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To filled in by the funeral 28a. Date of Injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 1 X Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 24 hours after death Funeral Director: 6 ☐ Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated Medical 29a, Certifier 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) (Check only and manner stated. within 2 To the I 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifier 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 20912 Takoma Park - 7701 Carroll Avenue, M. Kango, M.D. Nasreen_ 32. Registrar's Signature 31. Date filed (Month, Day, Year) State DEC 2 4 2009 Enua B. park Registrar

DHMH 17 Rev 1/2001

State of Maryland / Department of Health and Mental Hygiene 42523 1 - For State Registrar Certificate of Death 3 Time of Death 2. Date of Death Decedent's Name (First, Middle, Last) Month 25 M **Physician** /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner HOME If Under 1 Year | If Under 24 Hrs. Birthplace (State or Foreign Country) Date of Birth (Month, Day Social Security Number 7. Age (In yrs. last birthdey) **Funeral** Days Months Hours 19M 2DF 6 Director Usual Residence of Decedent filed within 72 hours after death with the Maryland 10d. Inside City Limits 10b. County 10c. City, Town or Location 10a. State show r then "natural", or Itams 23a or 28e-f shov the Medicul Exaction must be notified at 1 ☐ Yes 2 ☑ No Director 10g. Citizen of What Country? 10e. Street and Numbe 10f. Zin Code Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-II Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☐ No 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☐ No Specify Specify. þ JH11E 3 ☐ Widowed 4 ☐ Divorced Completed 16b, Kind of Business/Industry 16a. Decedent's Usual Occupation 15. Decedent's Education (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) Department of Health and Mental Hygiene. Importent: If item 27 is marked other then Elementary/Segondary (0-12) College (1-4or 5+) 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) and Mental 19a, Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) MARYANN TODD 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 1 □ Burial 2 □ Cremation 3 □ Removal from State injury or *4 □ Donation 5 □ Other (Specify) permit. 21. Signature of Funeral Service Licensee 22. Name and any ir HOME Het EDEXALSBURG, MD Approximate interval Between Onset and Death 23a. Pert1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final **Physician** /Medical resulting in death) Due to (of as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of) Examiner The law requires that the death certificate be executed and that initiated events resulting in death) Last Due to (or as a consequence of) the attending physicien arched for use as the burial-Division of Vital Records. P.O. Box 68760. Completed by Physician/Medical IF FEMALE 23c. If yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months? 2 Fetal death 3 Ectopic pregnancy Year Month Day 4☐Pregnant at time of death 5 Other (specify) ☐Yes 2☐No detached 9 Unknown 9 Unknown signed by 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. pe 2 1 No 3 Probably 4 Unknown 1 ☐ Yes 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has page 2 autopsy performed certificate 1 ☐ Yes 2 ☐ No 2 No the Hospital or Attending Physicien: director, Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 1 No 2 1 🗌 Yes 1 Inpatient 3 DOA 2 ER/Outpatient After this funeral 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of Injury 28c. Injury at Work? 28d. Describe how injury occurred Certification: 1. Natural 5 Pending 1 Tyes 2 No 2 Accident investigation nin 24 hours after death the Funeral Director: 6 Could not be determined 3 Suicide 281. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 - Homicide 29a. Certifier LE Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) within 2 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 29c. License number 0 2 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 31. Date liled (Month, Day, Year) Registrar's Signature State

DHMH 17 Rev 1/2001

Registrar

DEC 29 2009

/Medical **Examiner** 1 - For State Regist 1. Deceden

Director

Funeral

Completed by

Be ၉

Examiner

by Physician/Medical

Physician /Medical

Examiner

Funeral

	Please				nk. Ensure A	_		
For State Registrar		State of Ma			of Health and N of Death	Mental Hygien Reg. N	2000	1 42524
1. Decedent's Name	e (First, Middle, Las	st)				2. Date of Death Month	Day Year	3. Time of Death
n	Douglas	Scott	Vestra	nd			17, 2009	0712 ^M
		e street and number)			n, or Location of Death	4	c. County of Deat	
	reensboro			Dent			Caro1	
5. Social Security No. 212–78–3	1	M 2□F	e <i>(In yrs. last birthday)</i> Yrs.	If Under 1 Ye Months Da	ear If Under 24 Hrs. ays Hours Min.	8. Date of Birth (Month, Day, Yea	ar) Co	hplace (State or Foreign untry)
Usual Residence of	Decedent						- JUG Tic	
10a. State	10b. County		10c. City, Town or Lo					10d. Inside City Limits 1 ☐ Yes 2 및 No
Maryland	Caro	line	Dento				Division	A
10e. Street and Nun		D '		10f. Zip Coo			Citizen of What Co ted Stat	es of America
	eensboro	т	5		629			
11. Marital Status	OC	12. Was Decedent I		vvas Decedent If Yes, specify (t of Hispanic Origin? (Sp Cuban, Mexican, Puerto	респу Yes or No- Pican, etc.)	14. Race - Ame Black, White	
1 Never Marri	ied 2□ Married 4x Divorced	1 ∐Yes 2 ☑ 1 If Yes, Give Year or Dates:	NO .	1⊡Yes 2 1 ∑0	No Specify:			ucasian
(Spec	15. Decedent's Ed	lucation de completed)		dent's Usual O	ccupation lone during most of work etired)		Kind of Business/	Industry
Elementary/Secon		College (1-4or 5	o+)					
12 HS g1	rad		D	isabled		ne (First, Middle, Maid	en Surname)	
		Donald	Vestrand			_		
	Richard			- A	Sharon_		vning	Zin Codo)
	ame/Relationship (treet and Number or Ru			
	Vestrand	Mother			lyn Drive,		laryland Location - City or	
20a. Method of Disp 1X Burial 2		Removal from State	20b. Place of Dispo cemetery, cren				Ť	
4 ☐ Donation	5 ☐ Other (Specify	y)	<u> </u> Greensbo	ro Ceme	etery 12/2	1/2009 Gre	ensboro,	Maryland
21. Signature of Fu	uneral Service Licer	neone	22	2. Name and A	ddress of Facility Mo h Second St	ore Funera	al Home,	P.A.
23a. Part 1. Enter th	he disease, or comp	plications that caused	the death. Do not ent		f dying, such as cardiac			Approximate Interval Between
Immediate Cause ((Final	one cause on each lii	20.1	-0	arrana ral	13 12 h	10 hours	Onset and Death
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Sequentially list not if any, leading to im	mediate	Due to (or as	a consequence of):	the 1	3.00			
cause. Enter Unde Cause (Disease or that initiated events	erlying injury	C.						
resulting in death) I	Last	Due to (or as	a consequence of):					
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IF FEMALE: 23b. Was decedent		23c. If yes, outcome		⊒ Ectopic preg	nancy		23d. Date of de	
in the past 12 1 ☐ Yes 2 ☐	months?	4 🗌 Pregnant a		Other (specif			Month	Day Year
9 🗆 Unknown		9 Unknown						
Part II. Other signif	ficant conditions c	ontributing to death b	ut not resulting in the u	nderlying caus	e given in Part I.	23e. Did tobacc	co use contribute to	o the cause of death?
- q	119pe	75 M	ellitus			1 ☐ Yes	2 □ No 3 □ P	robably 4 🗆 Unknown
-	hu non	· linia.	emia			24a. Was an	24b. Were a	utopsy findings available
	Mari	11/2/01			·	autopsy performed	? prior to death?	completion of cause of
25. Was case refer	red to medical				26 Place of Dec	1 ☐ Yes 2 X	NO 1 1 LIYes	s 2 No
examiner?		Hospital: 1 ☐ Inpatie	ent 2 ☐ ER/Outpatier	nt 3D Dov	Other:	lome 5 Residence	6 □Other (0:	ecify)
27. Manner of Deat		1 inpatie	ry 28h Time of		4 L Nursing H Injury at Work?	28d. Describe how in		Joney
14 Natural	5 Pending investigation	(Month, Da	iy, Year) Injury	М 2001	Work? 1 ☐ Yes 2 ☐ No			
2 ☐ Accident 3 ☐ Suicide	6 ☐ Could not be		ury - At home, farm. str			28f. Location (Street	and Number or R	ural Route Number,
4 Homicide	determined	building, et	ury - At home, farm, str c. <i>(Specify)</i>			City or Town, St	tate)	

Completed 25. Was ca examin Be 1 ☐ Ye Certification: To 27. Manner 14 Na 2 Ac 3 □ Su 4 ∏ Ho t Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical

29c. License number
D 0047534

29d. Date signed (Month, Day, Year)

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

and manner stated.

M.D Wafik Zaki, M.
31. Date filed (Month, Day, Year) Denton, Maryland 21629 920 Market Street Registrar's Signature

State Registrar

DEC 2 1 2009

29b. Signature and title of certifier

09-10021 Janice Waudby		Please Typ	pe or Print i	n Black In	ndelible I	nk. En: f Health	sure	e All Cop	ies Are Hygiene	Legib	le.		
•	d#	7- For State FH TCHD	pha 12/3					a mornar	, g	Reg. No	. 20	09	42525
Physicia	an/	Decedent's Name (First, Midd	le,Last)						2. Date of Month	Day	Yea		Time of Death 2043 hrs
Medical Exami	ner	Janice Mary Hu 4a. Facility Name (if not institution	tchins Wa	udby umber)		4b. City, To	wn, or	Location of Dea		nber 23,	2009 4c. County o	of Death	
		29696 Tallaulah Lane		,		Easton					Talbot		
Funeral	Н	5. Social Security Number	6. Sex	7. Age (In yrs. I	last birthday)	If Under	1 Year		Irs. 8 Date	of Birth(M	M/DD/YYYY	9. Birthp Foreign	lace (State or
Director		070-60-9953	1 M 2 X F	- 55	55 Yr		Days	S Hours IV	May	22,	1954	Count	ry) England
an y		Usual Residence of Decedent 10a. State 10b. County		10c. City	, Town or Loca	tion						10	0d. Inside City Limits
) <u>*</u>	Ļ	MD Ta	1bot		Easton							1	X Yes 2 No
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th with lems 2 tems 2 st be n	Funeral	11. Marital Status 1 Never Married 2 XM						panic Origin? (, Mexican, Pue			14. Race White		n Indian, Black,
ter dea	Ē		1 Yes	2 X No	1	Yes 2	No	specify:			Specify:	Whit	e
ours af atural	d by	15. Decedent's Education (Spe	or Dates: cify only highest gra	de completed)				ion (Give kind of DO NOT use r		16b	. Kind of Bus	siness/Ind	ustry
6 5 72 ho an "nu ical Ex	lete	Elementary/Secondary (0-12)		1-4 or 5+)			•	DO NOT use	elired)				
5-0036 iled within 77 Hygiene. I other than	Completed	12 17. Father's Name (First, Middle	last)		<u>H</u>	<u>omemak</u>		18.Mother's Na	me (First, Mid	dle, Maide		n Ho	me
kee file	BeC	Unknown	, 2001)						Garner				
21; nould b nd Men is mar	5	19a. Informant's Name/Relations						t and Number o				n, State, Z	ip Code)
MD 2 sho alth and arm 27 is		Thomas Alvin W 20a. Method of Disposition	audby/hus		296 Place of Dispo			ah Land	e, East		MD 2:	1601 City or To	wn. State
altimore, mit. Pages I and spartment of Heal pportant: If iten	П	1 Burial 2 X Cremation		rom State	crematory or o	ther place)		To	n.4,20	10		-	lle, MD
it. Pagirtment per or o		4 Donation 5 Other S		Cn	esapeak 122	Name and A	ddrass	of Facility					
Ba perm Depa Impu		1/2/			Fe	11ows	, Не	elfenbe	in & N	ewnan	Fune	ral H	Home, P.A.
Physician		art I. Enter the dis se, or failure. List only one cause	complications that	caused the death	n. Do not e	the most of	ing.	SO T & TAPPA	d or respirator	y arrest,	floor, Shina	e III	Ap. 21601 Between Onset and
/Medical Examiner	1	Immediate Cause (Final disease	a Comp1			ronic	alc	oholis	n			_	Death
		or condition resulting in death)	Due to (or as	a consequence o	of):								
	Jer	Sequentially list conditions, if any, leading to immediate		a consequence o	of):								
	Examine	cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	С.	a consequence o	of):							-	
ecuted and transit	-	events resulting in death) Last	d										
be exection a sician a	Physician/Medica	X UNPENDED	AMENDED	23a,27	permE,	g899	1/8	3/10 TT					
Box 68760, cath certificate be exthe attending physician of for use as the burial.	/Me	IF FEMALE: 23b. Was decedent pregnant in t		outcome of preg	gnancy	etal death	3 [Ectopic preg	nancy	2	3d. Date of Month	delivery Day	y Year
x 68 h certi tendini use as	iciar	past 12 months?	4 Preg	nant at time of de	noth -	ther (Specif	L		y, id. 10y				
Bo ne deat the at	hys	1 Yes 2 No 9 V Un	9 01111					in Danil	230	Did tobacc	o use contri	bute to the	e cause of death?
, P.O. ires that the signed by	by F	Part II. Other significant condit	tions contributing t	to death but not r	resulting in the	underlying c	ause g	jiven in Part i	1	Yes 2			bly 4 Unknown
ords, I	ted									Was an	24b. V	Vere autor	osy findings available
COF law n has b	Completed							_	- II	autopsy performed	? d	leath?	npletion of cause of
Vital Rec ysician: The l his certificate		25. Was case referred to medica	at I		_	26	Place	of Death (Che		res 2	NO 1	✓ Yes	NO
Division of Vital Records, P.O tal or attending Physician: The law requires that the safter death at Director: After this certificate has been signed by led in by the funeral director, page 2 should be detaced.	To Be	examiner? 1 ✓ Yes 2 No	Hospital 1	Inpatient 2	ER/Outpatien	t 3 DO	А	Other Nur	sing Home	Resi	dence 6	Other: S	cene
n of V ding Phy After tl funeral		27. Manner of Death	28a. Date (Mont	e of Injury h, Day,Year)	28b. Time of	Injury 28	_	y at Work?	28d Desc	ribe how i	njury occurre	ed	
ivision or Attend after death Director:	atio	Pen	stigation					res 2 No	001	/01		an an Diseas	Doute Number City
Divis al or A s after al Dire	ertification	dete	ld not be 28e. Pla (Specify	ce of Injury - At h	nome, farm, stre	eet, factory, o	office b	uilding, etc.		wn, State)		er or Rura	Route Number, City
ion ion	O	29a. Certifier 1 Contituing R	hysician: To the be		dge, death occu	rred at the ti	me. da	ate and place, a	and due to the	cause(s)	and manner	as stated	
To the Hos within 24 h To the Fur	Medical	(Check only one) 2 Medical Exa	miner: On the basis and manner	of examination a	and/or investiga	ation, in my o	pinion	, death occurre	ed at the time,	date and	olace, and d	ue to the	cause(s)
F * F 8	Me	29b. Signature and title of certific		Stated		29c.	Licens	e number			d Date signe		
		UMBIZ					O.C.I	M.E.		De	ecember	24, 200	9
		30 Name and address of person	n who completed cau sistant Medical			Street Ro	ltima	ore MD 212	201				
	tate			egistrar's Signat	ure								
Darria	e lë Leo	31 Date filed (Month_Day, Year)	2009		h lon	Med							

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death B. Physician/ WHITE 23 L8 M OS EPHING Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death Anne Arundel Medical Center Anne Arundel Annapolis Social Security Number 7. Age (In yrs. last birthday If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign Funeral Months Days Mar. 21 1 M 2 Hours Min. 84 Virginia 231-20-4351 Director 1925 Usual Residence of Decedent ms 23a or 28a-f show must be notified at 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director 1 Yes 2 ☐ No MD Prince George's Bowie 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Completed by Funeral 3800 Enfield Chase Ct. #206 20716 USA 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11 Marital Status 14 Race - American Indian traumatic event, the Medical Examiner Armed Forces?
1 ☐ Yes 2 ☑ No 0. Black, White, etc. 1 Never Married 2 Married 3altimore, Maryland 21215-0036 1 ☐ Yes 2 🛛 No Specify. "natural", If Yes, Give 3 ☐ Widowed 4 ☐ Divorced Specify Year or Dates White 15. Decedent's Education 16a. Decedent's Usual Occupation 16b Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life, DO NOT use retired) and 2 should be filed within 72 Health and Mental Hygiene. em 27 is marked other than ' Elementary/Seconday (0-12) College (1-4 or 5+) Homemaker Own Home Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ပ Edison Ball Cecilia Gertrude Miller 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Donnen White / spouse 3800 Enfield Chase Ct. #206 20716 Bowie, MD 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Department of I Important: If it any injury or o 1 Burial 2 A Cremation 3 Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Bayview Crematory 12/17/2009 Baltimore, MD 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Beall Funeral Home 6512 NW Crain Hwy. Bowie, MD 20715 Part 1. Eyer the discrese, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, of heart failure. List only one cause on each line Approximate Interval Between On et and Death Immediate Jause Inal disease or condition Physician/ ory Medical resulting in death) Due to (or as a consequence of): Examiner Sequentially list conditions Examine rany, leading to infinediate cause. Enter Underlying Cause (Disease or iinjury Due to for as a consequence of: burial-transi death certificate be executed that initiated events Due to (or as a consequence of) resulting in death) Last attending physician Physician/Medical Box 68760 the as IF FEMALE: for use yes, outcome of pregnancy
☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? Month Day Year Pregnant at time of death 5 Other (specify) 1 Yes 2 signed by the a d be detached for 9 Unknown Records, P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 Yes 2 No 3 Probably 4 Onknown peen 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an this certificate has autopsy Hospital or Attending Physician; The L24 hours after death.
 Funeral Director: After this certificate h performed? 1 ☐ Yes 2 ☐ No Division of Vital 25. Was case referred to medica Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 No ည 1 🗌 Yes npatient 2 ER/Outpatient 3 DOA 27. Manner of Death 28a. Date of injury 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred (Month, Day, Year) Natural 5 Pending work? 2 🗌 No Accident 🗆 Investigation 3 Suicide
4 Homicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Medical 29a. Certifier critifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. within 2 3 Certifying Nurse Praction only one) 😮 To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29b. Signature and title of 2004 zy W

XH-6

State Registrar Name and address of pe

31. Date filed (Moi

DHMH 17 Rev 7/2009

pleted cause of death (Item 23a) (Type, Print)

Pegistrar's Signature

32.

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State 2_31_09
Registrat Americ#12_PerFH/InfimitPGCcc Certificate of Death Reg. No. 2. Date of Death 1. Decedent's Name 11:22 A^M 2009 16 DEC LAWRENCE PAUL WESSENDORF **Physician** /Medical 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) Examiner MONTGOMERY BETHESDA NATIONAL NAVAL MEDICAL CENTER Birthplace (State or Foreign Country)
 T if Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Ye. August 21, 1^{Year)} 1939 7. Age (In yrs. last birthday) 5. Social Security Number 6. Sex Hours Davs Iowa Months **Funeral** 1 M 2□F 70 485-48-2834 Director Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location death with the Maryland 10h County 1 □Yes 2 No 28a-f show permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylar Department of Health and Mental Hyglene. Important: If item 27 Is marked other than "natural", or items 23a or 28a-f show amy Injury or other traumatic event, the Madical Examiner cust be notified at once. Laurel Anne Arundel Maryland Director 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number USA 20724 209 Old Line Avenue 14. Race - American Indian, Black, White, etc. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Funeral 12. Was Decedent Ever in U.S. Armed Forces?

1 Yes 2 No 58-If Yes, Give Year or Dates 979 11. Marital Status Pages 1 and 2 should be filled within 72 hours after to nent of Health and Mental Hygiene. .nt; If item 27 Is marked other than "natural", or iten 1 ☐ Never Married 2 X Married Specify: White 1 ☐ Yes 2 📆 No Specify: altimore, Maryland 21215-0036 þ 3 Widowed 4 Divorced 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Completed 15. Decedent's Education (Specify only highest grade completed) Department of Defense Elementary/Secondary (0-12) College (1-4or 5+) Linguist 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Ruth Morgan George Wessendorf ပ္ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 209 Old Line Avenue, Laurel, Maryland 20724 Judith Wessendorf - Wife 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 1 ☐ Burial 2 X Cremation 3 ☐ Removal from State Glen Burnie, Maryland 12/22/2009 Atlantic Crematory, Inc. 4 □ Donation 5 □ Other (Specify) 22. Name and Address of Facility 7601 Sandy Spring Road 21. Signature Funeral Service Licens Fleck Funeral Home, Inc. Laurel, Maryland Approximate Interval Between Onset and Death their collections sed the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Part 1. Firter the disease, or complication send the shock, in heart failure. List only one cause on each line 23a. Part 1. Immediate Cause (Final Physician SEPSIS disease or condition resulting in death) Due to (or as a consequence of): /Medical Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examine Physician: The law requires that the death certificate be executed sician and burial-trans Due to (or as a consequence of) attending physician Division of Vital Records, P.O. Box 68760 Physician/Medical 23d. Date of delivery IF FEMALE: 23c. If yes, outcome of pregnancy Day Year 23b. Was decedent pregnant in the past 12 months? 1 Live birth 3 Ectopic pregnancy Month 2 Fetal death 5 Other (specify) Pregnant at time of death ☐Yes 2 ☐No nis certificate has been signed by the director, page 2 should be detached 9 DUnknown q □ Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 1 ☐ Yes 2 No 3 ☐ Probably 4 ☐ Unknown ģ Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performe 2 🗆 No 1 ☐ Yes 2 **[5t**No 26. Place of Death (Check only one) 25. Was case referred to medical Be Other: 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) Hospital 2 ER/Outpatient 3 DOA 1 Yes 2 No 1 🔀 Inpatient Certification: To this 28d. Describe how injury occurred 28c. Injury at Work? 28b. Time of within 24 hours after death.

To the Funeral Director: After this completely filled in by the funeral (28a. Date of Injury (Month, Day, Year) 27 Manner of Death Injury 1 🔀 Natural Hospital or Attending 5 Pending 1 ☐Yes 2 ☐ No 28f. Location (Street and Number or Rural Route Number, City or Town, State) investigation 2 Accident 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 6 Could not be determined 3 Suicide 4 Homicide

State

Registrar

Medical

29a. Certifier

(Check only one)

29b. Signature and title of certifier

30. Name and address of person

mo

completed cause of death (Item 23a) (Type, Print)

1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

| Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29c. License number

0101235548 (VA)

29d. Date signed (Month, Day, Year)

Dec 18, 2009

NATIONAL NAVAL MEDICAL CENTER

BETHESDA MD 20889-5600

State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) **Physician** December 25, 2009 0225 Francis Whitby Edward /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner Caroline Denton Caroline Nursing Home, Inc. If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, June 8, Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday, **Funeral** Hours Months Days 1919 1 € M 2 🗆 F Maryland 90 218-01-8535 Director Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 10b. County permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryla Department of Health and Mental Hygiene. Important; If Item 27 is marked other than "natural", or items 23a or 28a-f shov any injury or other traumatic event, the Medical Examiner must be notified at 28a-f show 1 ☐ Yes 2☐ No Ridgely Director Maryland Caroline 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number 21660 United States of America 12319 Crouse Mill Road Funeral 14. Race - American Indian, Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specity Yes or No If Yes, specity Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Black, White, etc 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☐ No Specify: þ Caucasian 3 Widowed 4 ☐ Divorced 1945 Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) School bus College (1-4or 5+) Elementary/Secondary (0-12) Farming/Auto/ Driver Farmer/Mechanic/Bus Driver 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be McMullen Elizabeth Whitby Ravmond Frank ဥ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)
PO Box 111, Hillsboro, Maryland 21641 19a. Informant's Name/Relationship (Type. Print) Daughter Olwynn Maddox 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State Greenmount Cemetery 12/30/2009 Hillsboro, Maryland 4 Donation 5 ☐ Other (Specify) 22. Name and Address of Facility Moore Funeral Home, P.A. 21. Simature f Funeral Şervi**ç**e Licər 12 South Second Street, Denton, Maryland 21629 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Can-Physician /Medical **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Day to for as a consequence off Completed by Physician/Medical Examiner To the Hospital or Attending Physician: The law requires that the death certificate be executed and Due to (or as a consequence of): Division or Vital Records, P.O. Box 68760, IF FEMALE If yes, outcome pf pregnancy
1 Live birth 2 Fetal death
4 Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months? 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ Year Month Day 1 Yes 2 No 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☐ No 24a. Was an autopsy performed? Yes 2 No page 2 1⊟ Yes Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: 1 Yes 2 No 2 ER/Outpatient 4 Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 1 Inpatient 3□ DOA Medical Certification: To 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 27. Manner of Death 1. Natural 28a. Date of Injury (Month, Day Year) Injury 5 ☐ Pending investigation 1 ☐ Yes 2 ☐ No 2 ☐ Accident 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 6 ☐ Could not be 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide within 24 hours To the Funeral to the cause(s) and manner as stated 29a. Certifier 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 29c. License number 31. Date filed (Month, Day, Year) Registrar's Signature State DEC 28 2009 Registrar

AS St DHMH 17 Rev 1/2001

			For State Registrar	State of Marylar		artment of H		nd Menta		ene 009	42529
	Physicia	_	Decedent's Name (First, Middle, Last)	Larry Ral	ph Wil.	lard		Mo	e of Death nth ober	Day Yea 14, 2009	
	/Medic Examin	al	4a. Facility Name (If not institution, give s			4b. City, Town, or		f Death	ODEL	4c. County of D	eath
Ī	Funeral Director		NMS Healthcare Ce 5. Social Security Number 216-66-1692 6. Sex	nter 7. Age (In yrs. M 2□F 53	. last birthday) Yrs.	If Under 1 Year Months Days	ersto If Under 2 Hours	Min. 8. Date	e of Birth inth, Day, Y Ch 18	(ear) 9. I	ington Birthplace (State or Foreign Country) Pennsylvania
	ס		Usual Residence of Decedent 10a. State 10b. County Maryland Freder		ity, Town or Lo	Smithsb	urg				10d. Inside City Limits 1 ☐ Yes 2X No
	with the a or 28s	Director	10e. Street and Number 4643 John Draper	Road		10f. Zip Code 217	83		100	g. Citizen of What $U.S.A$	· ·
36	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hyglene. Important: If item 27 is marked other than "natural", or Itams 23a or 28a-f show any injury or other traumatic evant, It a Medical Examinar must be notified at ance.	by Funeral		2. Was Decedent Ever in the Armed Forces? 1		Was Decedent of Hi If Yes, specify Cuba	spanic Orig n, Mexican Specify:	gin? (Specify Ye , Puerto Rican,	s or No- etc.)		mencan Indian, /hite, etc. White
Maryland 21215-0036	within 72 hou ene. than "natura ne Wedical E	Completed I	15. Decedent's Educ (Specify only highest grade Elementary/Secondary (0-12)	cation completed) College (1-4or 5+)	(Give	dent's Usual Occupa kind of work done o DO NOT use retired Winemaker	during most)	of working	10	6b. Kind of Busine	
land 2	ild be filed lental Hygi ked other ic evant, I	To Be Co	11 17. Father's Name (First, Middle, Last) Harold Ralph M	Villard				r's Name (First, Ruth Ma		aiden Sumame) Gewis	
Mary	12 shou h and M 7 Is mar traumat	-	19a. Informant's Name/Relationship (Type	oe, Print) (Brother)		ng Address (Street a					
Baltimore, I	Pages 1 and nent of Healt int: If item 2 iry or othar		Donald A. Willard 20a. Method of Disposition 1	20b. emoval from State	Place of Dispo cemetery, cre	Almost He psition (Name of matory or other plac el Cemete	(e)	Date Octobe 19, 200	r 20	Oc. Location - City	
Balti	permit. Departn Imports any inju		21. Signature of Funeral Service License	avis MO	1414	2. Name and Addres 12525 Bra					eral Home ryland 21783
	Pnysician		23a. Part1. Enter the disease, or complications shock, or heart failure. List only on immediate Cause (Final	cations that caused the dealer cause on each line.	ath. Do not en	ter the mode of dyin				st,	Approximate Interval Between Onset and Death
760,	math certificate be executed attending physician and for use as the burlal-transit	cal Examiner	disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	Due to (or as a consection of the to (or a) consection of the to (or a) consection of the to (or	equence of):			SCasa			
Box 68	The law requires that the death certifical tite has been signed by the attending phroage 2 should be detached for use as the	Physician/Medi	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	3c. If yes, outcome of preg 1 □ Live birth 2 □ Fe 4 □ Pregnant at time of 9 □ Unknown	tal death 3	□Ectopic pregnancy □ Other (specify) _	,			23d. Date of Month	f delivery Day Year
rds, P.O.	quires that I n signed by Ild be deta	by	Part II. Other significant conditions cor	ntributing to death but not re	esulting in the	underlying cause giv	en in Part I	. 2:			te to the cause of death? Probably 4 Dunknown
Division of Vital Records,		Completed							4a. Was ar autopsy perform ☐ Yes 2	prior deat	e autopsy findings available r to completion of cause of th? Yes 2□ No
i Vita	Physician: Th this certificate ral director, pag	o Be	25. Was case referred to medical examiner? 1 Yes 2 No	lospital: 1 ☐ Inpatient 2	☐ ER/Outpatie	int 3□ DOA Oth	ac.	of Death (Che ursing Home 5		a) nce 6 □Other (Specify)
ion of	ing After une	ation; T	27. Manner of Death 1 Natural 5 Pending 2 Accident investigation	28a. Date of Injury (Month, Day Year)	28b. Time Injury	Wor	yat k? Yes 2 □	No		w injury occurred	
Divis	ospital or Attand hours after death uneral Diractor: , ly filled in by the f	Certification:	3 Suicide 6 Could not be determined	28e. Place of Injury - At building, etc. (Spe	home, farm, s cify)	treet, factory, office			ocation (Str ity or Town		or Rural Route Number,
	I 4 II 0	edical (29a. Certifler 1 Certifying Physical Certifier 2 Medical Exemi	sician: To the best of my k ner: On the basis of exami and manner stated.	nowledge, dea nation and/or i	th occurred at the tin nvestigation, in my o	me, date ar opinion, dea	nd place, and du ath occurred at t	the time, da	ate and place, and	I due to the cause(s)
)	To tha within 2 To tha complet	Ň	29b. Signature and title of certifier	holm		29c. Licens	O GO	396	29	od. Date signed (A	
			30. Name and address of person who co	ompleted cause of death (It	em 23a) (Type	o, Print)	26	opal		c.t	
	Sta Regist	ate rar	31. Date filed (Month, Day, Year)	32 Registrar's Sig	nature	ake	lage	NSTOWI	۸,	WO	21140

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) Date of Death 3. Time of Death Physician/ Lucy Gehr Young Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death Washington Washington County Hospital Hagerstown 5. Social Security Number If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) Dec 3, 1928 6 Sex 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign **Funeral** Months 1 □ M 2 🛛 F Days Hours Country) Pennsulvania 80 218-24-7726 Director Usual Residence of Decedent or 28a-f shov 10b. County 10a. State 10c. City, Town or Location within 72 hours after death with the Maryland Ħ 10d. Inside City Limits Director or than "natural", or items 23a or 28a-f s the Medical Examiner must be notified Maryland Washington Smithsburg 1 Tes 2 No 10e. Street and Numbe 10f. Zip Code 10g. Citizen of What Country? Funeral 12041 Little Antietam Road 21783 U.S.A. 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-11 Marital Status 14. Race - American Indian, Armed Forces?
1 ☐ Yes 2 🔀 No If Yes, specify Cuban, Mexican, Puerto Rican, etc. Black, White, etc. 1 Never Married 2 Married ģ Maryland 21215-0036 1 ☐ Yes 2 X No Specify: If Yes, Give Specify: 3 X Widowed 4 Divorced Completed White Year or Dates 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) should be filed within 72 land Mental Hygiene. Elementary/Seconday (0-12) College (1-4 or 5+) 12 Homemaker Home Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Department of Health and Menta Important: If item 27 is marked any injury or other transpine. ည Harriet Riddlemoser Paul B. Shank 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Michael S. Young (Son) 19 Grove Creek Circle Smithsburg, Maryland 21783 Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Date 1 Burial 2 Cremation 3 Removal from State October Smithsburg, Maryland 4 Donation 5 Other (Specify) Smithsburg Cemetery 2009 Signature of Funeral Service Licensee Davis Funeral Home 22. Name and Address of Facility J.L.MO 1414 12525 Bradbury Ave. Smithsburg, Maryland 21783 1 Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dving, such as cardiac or respiratory arrest. Approximate Interval Between Onset and Death shock, or heart failure. List only one cause on each line. Immediate Cause (Final Physician/ disease or condition resulting in death) 1 carl Medical Due to (or a a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Examine Hospital or Attending Physician: The law requires that the death certificate be executed and that initiated events resulting in death) Last Due to (or as a consequence of): attending physician for use as the burial Physician/Medical P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?

1 Yes 2 No Year Day Pregnant at time of death
Unknown 5 Other (specify) ed by the a 9 Unknown signed by t Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I 23e. Did tobacco use contribute to the cause of death? 2 Division of Vital Records, 1 Yes 2 No 3 Probably 4 Unknown Completed page 2 should peen 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has autopsy 1 ☐ Yes 2 ☐ No 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Other: 1 Inpatient 2 XER/Outpatient 3 I DOA 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) To the Funeral Director: After this completed filled in by the funeral directions 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at Certificate: 28d. Describe how injury occurred injury Natural 5 Pending work? 1 ☐ Yes 2 ☐ No after death. Accident Investigation M Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined within 24 hours a Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. (Check Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 3 🗆 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one)

DHMH 17 Rev 7/2009

State Registrar 29b. Signature and title of certifie

31. Date filed (Month, Day, Year)

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

32. Registrar's Signature

29c. License number

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. Amend Items State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month 12 Day 30 Physician/ 1458 Clara Eugene Anderson Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner N/A Union Memorial Hospital Baltimore If Under 1 Year If Under 24 Hrs. 8. Date of Birth Birthplace (State or Foreign Country) Social Security Number 7. Age (In vrs. last birthday **Funeral** 4-9-192 Hours Min. 1 □ M 2 🛣 F 88 Director 251-22-2571 C Usual Residence of Decedent permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at 10d. Inside City Limits 10a. State 10c. City, Town or Location Director 1X Yes 2 No MD n/a Baltimore 10g, Citizen of What Country? 10e. Street and Number 10f. Zip Code Funeral 4803 Tamarind Road 21209 USA Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Was Decedent Ever in U.S 11. Marital Status Armed Forces Black, White, etc. by 1 Never Married 2 Married ☐ Yes 2X No Baltimore, Maryland 21215-0036 1 ☐ Yes XXNo Specify If Yes, Give Specify: Black 3 X Widowed 4 Divorced Completed Year or Dates 16a. Decedent's Usual Occupation 15. Decedent's Education 16b. Kind of Business Industry 11nk (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) Elementary/Seconday (0-12) 8th grade College (1-4 or 5+) Nursing Assistant Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) 2 Charles Droze Olive Gibbs 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) Ivory Tucker-Son MD 21140 566 Riva, Laurel Road 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 1 XBurial 2 Cremation 3 Removal from State King Memorial Pk 1-12-2010 Randallstown, MD 4 ☐ Donation 5 ☐ Other (Specify) March East F/H 21. Signature of Funeral Service Licensee 22. Name and Address of Facility l and 1101 E. North Avenue BALTO, MD 21202 a 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between shock, or heart failure. List only one cause on each line Onset and Death Immediate Cause (Final Ph sician/ syndrone 212992 inknown disease or condition resulting in death) Severe Medical Due to (or as a consequence of) Examiner 5-10 mmute aspiration lung וחו טחץ Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or linjury that initiated across to the control of the con Examine Due to (or as a consequence of) Probable Complications of Multiple Myeloma Hospital or Attending Physician: The law requires that the death certificate be executed 24 hours after death.

Funeral Director: After this certificate has been along the tendent. OVED BY MEDICAL EXAMINER use as the burial-tran that initiated events Due to (or as a consequence of) resulting in death) Last CERTIFICATIO Physician/Medical Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ctopic pregnancy
5 Other (specify) in the past 12 months?
1 ☐ Yes 2 ☐ No Month Dav Year 4 Pregnant g Unknown Pregnant at time of death To the Hospital or Attending Physician: The law requires that the dea within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the a completed filled in by the funeral director, page 2 should be detached formula to the funeral director. 1 ☐ Yes 2 ☐ Unknown P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 ☐ Yes 2 🗷 No 3 ☐ Probably 4 ☐ Unknown Records, 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed 1 Yes 2 No Yes 2 X No Division of Vital Be 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) မ 1 Inpatient 2 K ER/Outpatient 3 I DOA 28a. Date of injury (Month, Day, Year) Certificate: 27. Manner of Death 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 🛮 Natural 5 Pending 1 ☐ Yes 2 ☐ No 2 Accident
3 Suicide Investigation 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29d. Date signed (Month, Day, Year) 29b. Signature and title of certific 29c. License number

State Registrar

33H.

Poul asarv

ASARO, MD

Louis S.

31. Date filed (Month, Day, Year)

JANOE

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

arko

E. University

MD

32. Registrar's Signature

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Parkway.

12/30/04

Buthner, MD

		Registrar 1. Decedent's Name (First, Middle,	ms 23a,25						2. Date of Dea	ath	2009	3. Time of Dea
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Examir		4a. Facility Name (If not institutioh,				4b. City, Towr	n, or Location	of Death		4c. C	County of Deat	h
/	М		mar kind	Medica	al Center	Be		we				
Funeral Director		5. Social Security Number (127–36–1110	5. Sex / 7. 1 ☑ M 2 ☐ F	. Age <i>(In yrs.)</i> 72	last birthday) Yrs.	If Under 1 Ye Months Day		Min.	8. Date of Birt (Month, Da)5/22/1	y, Year)	Co	hplace (State or Fo. untry)
		Usual Residence of Decedent		12))/ 44/ 1	.937	Jai	naica
rylan ihow	_	10a. State 10b. County		10c. City	y, Town or Loca	ation						10d. Inside City Li
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law requires that the death certificate be executed has been signed by the attending physician and a 2 should be detached for use as the burial-transit	Be Completed by Physician/Medical	Cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 Yes 2 No 9 Unknown Part II. Other significant condition 25. Was case referred to medical examiner? 1 Yes 2 Tho 27. Manner of Death 1 Natural 5 Pending investigat 1 Accident 3 Suicide 4 Homicide 1 Certifying (Check only 2 Medical E)	b. Due to for c. Due to for d. 23c. If yes, outco 1	r as a consequence of pregnanth 2 ☐ Fetal fint at time of dwn th but not result injury Day, Year) Injury Day, Year) est of my kno sis of examina	uence of): uence of): uence of): leath 3 leath 5	Other (specify derlying cause 3 □ DOA □ 28c. In V In	ancy) given in Part 26. Plac Other: 4 \(\text{N} \) njury at Vork? 1 \(\text{Yes} \) 2 \(\text{Ce} \)	RTIFICATION I. e of Death ursing Hom 21]No 21 und place, a	23e. Did to 1 24a. Was autor perfo 1 1 Yes (Check only one 5 Resided) 8d. Describe I	obacco us Yes 2 an an syy rmed? 2 Ano one) dence 6 how injury Street and cause(s) date and	Month se contribute to No 3 Pi 24b. Were au prior to death? 1 Yes Other (Spe occurred	by Year to the cause of death robably 4 Unkrutopsy findings avaicompletion of cause (5) The cause of death robably 4 Unkrutopsy findings avaicompletion of cause (5)
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law requires that the death certificate be executed has been signed by the attending physician and a 2 should be detached for use as the burial-transit	Certification: To Be Completed by Physician/Medical	Cause Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	b. Due to for C. Due to for d. 23c. If yes, outco 1 Live bir 4 Pregna 9 Unknow s contributing to death at the 28a. Date of (Month, to be ded) Physician: To the becaminer: On the bas and manner	r as a consequence of pregnarth 2 □ Fetal rate of dwn th but not result injury Day, Year) Injury Day, Year) If Injury - At ho, etc. (Specify est of my known of stated.	uence of): uence	Other (specify derlying cause 3 □ DOA 28c. li M 1 at, factory, office occurred at the estigation, in m 29c. Lice	ancy) given in Part 26. Plac Other: 4 \(\text{N} \) njury at Vork? \(\text{Yes} \) 2 \(\text{Ce} \) e time, date a ny opinion, de	RTIFICATION I. e of Death ursing Hom 28 INO 28 and place, a ath occurre	23e. Did to 1 24a. Was autoperforment of the second of the	obacco us Yes 2 an Ssy rrmed? 22 No one) dence 6 how injury Street and cause(s) date and 29d. Date	Month se contribute to a cont	by Year to the cause of death robably 4 Unkrutopsy findings avaicompletion of cause (5) The cause of death robably 4 Unkrutopsy findings avaicompletion of cause (5)

DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) Year 4.15 PM DECEMBER, 05 200° HILDA 4b. City, Town, or Location of Death 4c. County of Death 4a. Facility Name (If not institution, give street and number) BALTIMORE JOHN HOPKINS BAYVIEW MEDICAL LENTER 9. Birthplace *(State or Foreign Country)* Maryland 8. Date of Birth (Month, Day, Year) March 8,1925 If Under 1 Year | If Under 24 Hrs. 6. Sex 7. Age (In yrs. last birthday) Min. Months Days Hours 1 □ M 2√2 F 220-14-1125 Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 10a. State 10b. County 1 ☐ Yes 2 ☐ No Dunda1k Baltimore Maryland 10g. Citizen of What Country? 10f, Zip Code 10e. Street and Number 3534 McShane Way United States 21222 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 1 No If Yes, Give Year or Dates: 14. Race - American Indian, Black, White, etc. 11. Marital Status 1 Never Married 2 Married 1 □Yes 2 No Specify. Specify: White 3 Widowed 4 Divorced 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Manufacturing Factory Worker 8_Years 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Ada Belle Latham John Frank 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 3534 McShane Way Dundalk, Maryland 21222 19a. Informant's Name/Relationship (Type. Print) Mr. John Betts (Son) 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State Hilltop Service Corp. 12/9/2009 Towson, Maryland 4 ☐ Donation 5 ☐ Other (Specify) 21. Signal of Funeral Service Licensee 2. Name and Address of Facility
Duda-Ruck Funeral Home of Dundalk, Inc. 7922 Wise Ave. Dundalk, Maryland 21222 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) BLEED PONTINE Due to (or as a consequence of): SUB ARACHNOID & Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) MNER Due to (or as a consequence of) CERTIFIC 23c. If yes, outcome of pregnancy
1 Live birth 2 Fetal death
4 Pregnant at time of death 23d. Date of delivery 3 🗌 Ectopic pregnancy Month Dav 5 Other (specify)

permit. Pages 1 and 2 should be filed within 7. Department of Health and Mental Hygiene. Important: If item 27 is marked other than "na any injury or other traumatic event the page. **Physician** /Medical Examiner

Physician

Examiner

Funeral

Director

28a-f show

Director

Funeral

Completed

Be

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7 is marked other than "natural", or items 23a or 28a-f shor traumatic event, the Medical Examiner must be inclified at

filed within 72 hours after death with

Maryland 21215-0036

altimore,

/Medical

Examiner physician and the burial-trans physician Physician/Medical as certificate has been signed by the attending irector, page 2 should be detached for use as Completed by To the Hospital or Attending Physician: within 24 hours after death.

To the Funeral Director: After this certific completely filled in by the funeral director, Be Medical Certification; To

The law requires that the death certificate be executed

Hospital or Attending Physiclan:

Division of Vital Records, P.O. Box 68760,

23b. Was decedent pregnant in the past 12 months? ☐Yes 2☐No 9 Unknown

23e. Did tobacco use contribute to the cause of death?

2 No

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed

25. Was case referred to medical examiner?
1 XYes 3 Ne 27. Manper of Death

Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 28a. Date of Injury (Month, Day, Year) 28b. Time of 5 Pending investigation

Other: 4 \(\text{Nursing Home} \) 5 \(\text{Residence} \) 6 \(\text{Other} \) (Specify) 28c. Injury at Work?

26. Place of Death (Check only one)

1 □Yes

28d. Describe how injury occurred

2 No

1 ☐ Yes 2 ☐ No 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a, Certifier 29b. Signature and title of certifier

Natural

2 Accident

3 Suicide

4 Thomicide

📈 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29d. Date signed (Month, Day, Year) 29c. License number

30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 4940 EASTERN AVENUE BALTZMORE MD 21224

MADHAVI JINKA MBBS

6 Could not be

determined

31. Date filed (Month, Day, Year) JAN 0 6 2010

√32. Registrar's Signature

State

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 2009 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ William B. Beck 9:15 A M 2009 Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death 1539 S. Rolling Road Halethorope Baltimore 5. Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** 1 ₹ M 2 □ F Months Hours Min. Oct. 18, Year 953 220-56-0834 56 Country) Director Usual Residence of Decedent 28a-f show 10b. County 10a. State 10c. City, Town or Location injury or other traumatic event, the Medical Examiner must be notified at 10d. Inside City Limits Director MD Baltimore Halethorpe 1 Tyes 2 No 10e. Street and Number 10f. Zip Code 23a or 10g. Citizen of What Country? Funeral 1539 S. Rolling Road 212278 United States 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 11 Marital Status 14. Race - American Indian, Armed Forces? Black, White, etc. 1 Never Married 2 Married ŏ ģ 1 Yes 2 No Specify: White If Yes, Give Year or Dates and Mental Hygiene. is marked other than "natural", 3 Widowed 4 Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) unknown unknown Photographer Photography Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ٥ Charles Beck Irene Nowogorski 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 350 Catherine St., Bel Air, MD 21014 permit. Page 1 and 2 sh Department of Health ar Important: If item 27 is any injury or other trau Valerie Beck - Daughter Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State ☐ Barial 2 【**XCremation 3 ☐ Removal from State Atlantic Crematory 1-2-2010 4 Dunation 5 Other (Specify)
Signature of Fund at Service License Glen Burnie MD 22. Name and Address of Facility Ambrose Funeral Home, Inc. 1328 Sulphur Spring Rd., Arbutus, MD 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final) GASTROINTESTINAL Physician/ disease or condition Medical resulting in death) Due to (or as a consequence of): Examiner UARICES ESOPHAGEM Sequentially list conditions, Examine cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of, physician and s the burial-transit 1 RRHOSIS Due to (or as a consequence of): Physician/Medical HEPATITIN ALCOHOLIC IF FEMALE: 23c. If yes, outcome of pregnancy

1 Live Birth 2 Fetal death
4 Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) in the past 12 months? 4 Pregnant at time of death 9 Unknown Yes 2 No 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Completed 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a, Was an autoosy 1 Yes 2 No 1 🗌 Yes the Hospital or Attending Physician: 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Hospital: 2 No Other: ဂ 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of Certificate: 28c. Injury at 1 Natural 28d. Describe how injury occurred 5 Pending injury work? 1 ☐ Yes 2 ☐ No n 24 hours after death. le Funeral Director: Af bleted filled in by the fu ☐ Accident Investigation 3 Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 28f. Location (Street and Number or Rural Route Number, Medical 29a Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated (Check Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) ATTENDING 00056948 2009 31 DEC 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) BATIMONE NO 21201 300 ANDONT PLACE STUSE 3H TANSINDA 31. Date filed (Month, Day, Year) -State Registrar

Baltimore, Maryland 21215-0036

Box 68760

P.O.

Records,

of Vital

Division

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

Amend Item 11 per spouse 6901 3/2/10 dk

Amend Item 25 per dr., 8899,01/07/10, dhb

Certificate of Death

Reg. No. 1 - For A State Registrar 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month 2 Physician BERNARD COSBY 0500 A M 25 2009 /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner RANDAUSTOWN BALTIMORE SEASONS HOSPICE If Under 24 Hrs. 8. Date of Birth
Hours Min. Month, Day, 9. Birthplace (State or Foreign Country) 5. Social Security Number 7. Age (In yrs. last birthday **Funeral** 1**M**M 2□ F 212-34-3230 77 04 12 Director Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits show 10a. State 10b. County and Mental Hygiene. Is marked other than "natural", or items 23a or 28a-f show aumatic event, tre Mydical Evandrar must be notified at 1XYes 2 ☐ No Director MD BALTIMORE 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number with WEST GARRISON AVE 21215 USA 4020 Funeral death 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black White etc filed within 72 hours after 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐Yes 2 No Specify: Specify: BLACK ⋛ 3 ☐ Widowed 4 🛣 Divorced Completed 16a Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) TRUCKING College (1-4or 5+) TRUCK DRIVER 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Mental 1 JAMES COSBY SADIE JACKSON Pages 1 and 2 should 2 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) NICOLE COSBY-DYER/DAUGHTER permit. Pages 1 and 2 s Department of Health a Important: If item 27 Is any injury or other trau once. 4020 WEST GARRISON AVE, BALTIMORE, MD, 21215 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 1 Burial 2 Cremation 3 Removal from State GREENMOUNT CREMATORY 12 29 2009 BALTIMORE, MD 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility VAUGHN C. GREENE FUNE ALSELVICE 21. Signature of Funeral Service Licenses 8728 LIBERTY ROAD, RANDAUSTOWN, MD 21133 Approximate Interval Between Onset and Death 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart tailure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) **Physician** Waytahe Colon /Medical Due to (or as a consequence of) **Examiner** Sequentially list conditions, if any, leading to immediate causs. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examine Due to (or as a consequence of): sician and burial-trans Due to (or as a consequence of): P.O. Box 68760, attending physician for use as the buria death certificate be Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Month Day Year signed by the a 5 ☐ Other (specify) ☐Yes 2☐No 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Division of Vital Records, 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Canknown cate has been si page 2 should t Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performe this certificate 1 ☐ Yes 2 No 1 ☐ Yes 2 ☐ No To the Hospital or Attending Physician: within 24 hours after death.

To the Funeral Director: After this certifica completely filled in by the funeral director, p 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) 1∐Yes 2XNo Hospital: Other: 4 Nursing Home 5 Residence Other (Specify) Wakey has i ၉ 1 Inpatient 2 I ER/Outpatient 3 I DOA 28a. Date of Injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: 5 Pending investigation 1 Alatural 2 ☐ Accident 1 ☐ Yes 2 ☐ No 6 ☐ Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide 29a. Certifier Ecrtifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical (Check only one) Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifier Mul 5 29 DA7683 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Man Shus Mille 21136 31. Date-filed (Month, Day, Year) 2. Registrar's Signature State JAN 0 7 2010 Registrar

DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State
Registra Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death 5:48 PM Physician/ ames Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Towson Baltimore Center Gilchrist Hospice 8. Date of Birth (Month, Day, Year) Jan 31, If Under 1 Year If Under 24 Hrs 9. Birthplace (State or Foreign 7. Age (In vrs. last birthdav 5. Social Security Numbe 6. Sex Funeral Min. Months Days Hours Maryland 1 W 2 - F 87 Director 217-18-2446 Usual Residence of Decedent ral", or items 23a or 28a-f show Examiner must be notified at 10c. City. Town or Location 10d. Inside City Limits 10b. County 10a. State be filed within 72 hours after death with the Maryland Director 1 Yes 2 No Towson Baltimore 10f, Zip Code 10g, Citizen of What Country? 10e. Street and Number Funeral United States 21286 Joppa Rd. 205 E. Apt. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 12. Was Decedent Ever in U.S. 11 Marital Status Armed Forces? Black, White, etc. 1 Never Married 2 Married by Maryland 21215-0036 1 Yes 2 No Specify. Specify: White "natural", 3 Widowed 4 Divorced Completed Year or Dates. 1944-46 other traumatic event, the Medical 16a. Decedent's Usual Occupation (Give kind of work done during most of working life, DO NOT use retired) 15. Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) id Mental Hygiene. marked other than " College (1-4 or 5+) 5+ Elementary/Seconday (0-12) Crockett Associates Civil Engineer Be 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) မ Josephine R. Gates David Thompson Crockett Page 1 and 2 should 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Department of Health and N Important: If item 27 is me any injury or other trauma 19a. Informant's Name/Relationship (Type, Print) 1317 N. Palmway Lake Worth, FL 33460 Crockett /Son James Baltimore, 20b. Place of Disposition (Name of cemetery, crematory or other place) Date Jan 02 20c. Location - City or Town, State 20a. Method of Disposition 1 Burial 2 Cremation 3 Removal from State Beltsville, Maryland 2010 Chesapeake Crematory 4 Donation 5 Other (Specify) permit. Signature of Funeral Service Licenses M01443 22. Nameral Alternatives 8717 Green Pastures Drive Towson Maryland 21286 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Betweer **Qnset and Death** Immediate Cause (Final Physician/ disease or condition Medical resulting in death) Due to (or as a consequence of) Examiner Sequentially list conditions, Examine Due to (or as a consequence of) if any, leading to immediate Cause (Disease or iinjury that initiated events The law requires that the death certificate be executed and burial-trar Due to (or as a consequence of) resulting in death) Last attending physician Physician/Medical Box 68760 use as the IF FEMALE: , outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ Live Birth 2 Fetal death 1 Live Birth
4 Pregnant
9 Unknown for in the past 12 months? Month Day Year Pregnant at time of death signed by the a 2 No 9 Unknown P.O. 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I ğ 1 Yes 2 No 3 Probably 4 Unknown Records, Completed been 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an page 2 s autopsy has perform 2 2 No 1 Yes certificate or Attending Physician: 25. Was case referred to medical 26. Place of Death (Check only one) Division of Vital director, Be examiner? Hospital Other: 2 No 4 Nursing Home 5 Residence 6 Nother (Specify) 1 Tyes 1 Inpatient 2 ER/Outpatient 3 DOA ဂ္ this funeral 28b. Time of 28c. Injury at 27. Manner of Death 28a. Date of injury 28d. Describe how injury occurred Certificate: within 24 hours after death.

To the Funeral Director: After to ompleted filled in by the funera (Month, Day, Year, injury Natural 5 Pending 1 ☐ Yes 2 ☐ No Investigation Accident 28f. Location (Street and Number or Rural Route Number, City or Town, State) Suicide 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide determined

Hospital the

> State Registrar

Medical

29a. Certifie

only one)

29b. Signature and title of certifier

Certifying Nurse Practioner: To the best of my knowledge, death or

32. Registrar

30. Name and address of person who completed cause of death (Item 23a) (Type, Print

Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated

urred at the time, date and place, and due to the cause(s) and manner as stated.

29d. Date signed (Month. Day, Year,

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Amend Items 25,27,28a-f per me, 889, 01706/10dhB 1 - For State Registrar Reg. No. 2. Date of Death 1. Decedent's Name (First, Middle, Last) Month Essie **Physician** Mae Davis 10:50 AM 2009 /Medical 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number **Examiner** Francis Baltimore Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day Year) 04-06-192 Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) **Funeral** Months Days 1□ M 2 F 88 Yrs. Director Usual Residence of Decedent filed within 72 hours after death with the Maryland 10d. Inside City Limits 10c. City, Town or Location 10a. State th and Mental Hygiene. 7 is marked other than "natural", or items 23a or 28a-f show traumatic event, It a Medical Exeminational to rediffed at Baltimore 1 Pres 2 No Funeral Director MD 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number 2545 Francis 2121 USA 14. Race - American Indian. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Was Decedent Ever in U.S. Armed Forces? 11. Marital Status Black, White, etc. 1 Yes 2 No
If Yes, Give
Year or Dates: 1 Never Married 2 Married 3 Widowed 4 Divorced 1 □Yes 2 ■No Specify: Maryland 21215-0036 Specify: Black Completed by 16b. Kind of Business/Industry 16a Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) Montebello Hopital College (1-4or 5+) Food Service 18. Mother's Name (First, Middle, Maiden Surname, Father's Name (First, Middle, Last) Be should be illabreu 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) Francis St. Baltimore, MD 21217 1 and 2 s Health a Kobinson/Daughter 2545 Marjorie Department of Health a Important: If item 27 is any Injury or other tra once. Baltimore, Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Pages 1 Ridge 12/30/2009 Pikesville, MD
22. Name and Address of Facility Voughn C. Greene Cuneral 85. 1 ■ Burial 2 Cremation 3 Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee iberty Rd. Randellstown MD 21133 Vauch 7281 23a. Part 1. Enter the distase, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or hear failure. List only one cause on each line. Immediate Cause (Final everal purily **Physician** NUTRY disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner D BY MEDICAL EXAMINER requires that the death certificate be executed sician and burial-trans CERTIFICATION Due to (or as a consequence of): physician Physician/Medical the attending p IF FEMALE: yes, outcome of pregnancy
☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Month Year in the past 12 months? 4 Pregnant at time of death 5 Other (specify) 1 ☐ Yes 2 No P.O. cate has been signed by the page 2 should be detached 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Records, ģ 3 Probably 4 Unknown **2** No 1 Tes Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performe HYPERTENSION certificate 1 ☐ Yes 2 No 1 □Yes 2 🗖 No Division of Vital Hospital or Attending Physician: 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Be Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 X Yes 2 Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA this Certification: To 28a. Date of Injury (Month, Day, Year) After thi funeral 28b. Time of Injury
Unknown M 28d. Describe how injury occurred 27. Manner of Death 28c. Injury at Work? 5 Pending investigation (Month, **2009** Natural Subject fell 1 Natural 2 Accident 1 □Yes 2**X** No death. within 24 hours after death

To the Funeral Director:
completely filled in by the i 6 ☐ Could not be determined 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number City or Town, State) 2545 Francis 3 ☐ Suicide 2545 Francis St. 4 \(\text{Homicide} \) Baltimore,MD Home 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Medical 29a. Certifier (Check only one) within 2 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 29c. License number 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 2411 W. Belvedere Are. Be wise mo

DHMH 17 Rev 1/2001

State

Registrar

31. Date filed (Month, Day, Year)

JAN 0 6 2010

Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month Nelson O. Donnelly December 2009 4:30 P 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Morningside Assisted Living Ellicott City Howard Birthplace (State or Foreign Country) If Under 1 Year If Under 24 Hrs.

Months Days Hours Min. 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday 8. Date of Birth (Month, Day, Year) Days 1 X M 2 ☐ F 216-16-8542 86 Oct. 30, 1923 Maryland Usual Residence of Decedent 10h County 10c. City, Town or Location 10d. Inside City Limits 10a State 1 ☐ Yes 2 No MD Howard Ellicott City 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number 5330 Dorsey Hall Drive #306 21042 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 12. Was Decedent Ever in U.S. Armed Forces? 11. Marital Status Black, White, etc. Armed Forces: 1 124 Yes 2 □ No If Yes, Give Year or Dates: WWII 1 ☐ Never Married 2X Married 1 ☐ Yes 2 ☑ No Specify: White 3 Widowed 4 Divorced 16b Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Contract Administrator Westinghouse 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Oliver Ray Donnelly Mary Fell 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 5330 Dorsey Hall Drive #306; Ellicott City, MD 21042 Ruby Donnelly Wife 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place, Date 20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4□Donation 5₺Other (Specify)Entombment Loudon Park Mausoleum 1/6/2010 Baltimore, MD 22. Name and Address of Facility Sterling Ashton Schwab Witzke Funeral Home of Catonsville, Inc. 1630 Edmondson Avenue; Catonsville, 21228 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Myocardial Infarction disease or condition resulting in death) Due to (or as a consequence of): Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Due to (or as a consequence of) IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Month Day in the past 12 months? 1 □Yes 2 □ No 4 ☐ Pregnant at time of death 5 ☐ Other (specify) 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 1 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy perform 2 🗆 No 1 ☐Yes 2 No 1 ☐ Yes 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1∐ Yes 2≹ No 1 Inpatient 2 ER/Outpatient 3 DOA 28d. Describe how injury occurred

Box 687605 P.0. Division of Vital Records,

Examiner Hospital or Attending Physician: The law requires that the death certificate be executed attending physician and for use as the burial-transi cate has been signed by the page 2 should be detached certificate funeral director, this After 1 To the nusprace within 24 hours after death.

To the Funeral Director; Af

Physician

/Medical

Examiner

Funeral

Director

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Director

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Certification: To

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29b. Signature and title of certifier

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permit. Pages 1 and 2 sh Department of Health and Important; If item 27 is in any Injury or other traun once.

Physician

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State Registrar

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 25. Was case referred to medical examiner? 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of 28c. Injury at Work? Injury 1 X Natural 5 Pending 1 ☐ Yes 2 ☐ No investigation 2 Accident 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 ☐ Homicide 12 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29a, Certifier 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) (Check only and manner stated.

28f. Location (Street and Number or Rural Route Number, City or Town, State)

January 4, 2010

29d. Date signed (Month, Day, Year) 29c. License number

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

6334 Cedar Lane, Suite 103; Columbia, MD

ORIGINAL

D47447

31. Date filed (Month, Day, Year) 32. Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar amend 20-22 per F.H. g899 177/10 kb Death Reg. No. 2. Date of Death Decedent's Name (First, Middle, Last) **Physician** 2009 222 /Medical 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) **Examiner** Baltmire 8. Date of Birth (Month, Day, OS | O \$ Birthplace (State or Foreign Country) If Under 1 Year | If Under 24 Hrs. Age (In yrs. last birthday) **Funeral** Min. 1 □ M 2 🗷 F Days Hours Yrs. Infant 12009 Marylan Director Usual Residence of Decedent 1 and 2 should be filed within 72 hours after death with the Maryland Health and Mental Hygiene.

Pen 27 is marked other than "natural", or items 23a or 28a-f show 10d. Inside City Limits 10c. City, Town or Location 10a. State 10b. County permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryla Department of Health and Mental Hygiene. Important: If Item 27 Is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at 1 Ves 2 □ No Funeral Director 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number 5226 thank USA 21216 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, 12. Was Decedent Ever in U.S. Armed Forces? 11. Marital Status Black, White, etc. 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: 1 Never Married 2 Married 1 ☐ Yes 2 No Maryland 21215-0036 Specify: Black Completed by 3 Widowed 4 Divorced 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) nfan. 18. Mother's Name (First, Middle, Maiden Surna 17. Father's Name (First, Middle, Last) Be ၉ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) me 3altimore, 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 Removal from State **Bayview Crematory** 8/13/09 Baltimore 4 □ Donation 5 □ Other (Specify) 21. Signature of Funeral Service Licensee 22. Name and Address of Facility 1201 Dundalk Ave Robert J. Godack, Jr. Kaczorowski Funeral Home 21222 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) extreme **Physician** Mins /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Dua to (or as a consequence of) Examiner requires that the death certificate be executed burial-tran and Due to (or as a consequence of) Box 68760. physician Physician/Medical the as attending IF FEMALE: for use a 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Month Year Day in the past 12 months? 1 ☐ Yes 2 ☐ No 4☐Pregnant at time of death 5 Other (specify) P.O. detached 9 Unknown 9 Unknown þ 23e. Did tobacco use contribute to the cause of death? signed I Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Records, Completed by 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of 24a. Was an page 2 s certificate has autopsy performed? ∕es 2☑No death? 2™No 1☐ Yes Division or Vital To the Hospital or Attending Physician: within 24 hours after death.

To the Funeral Director: After this certifica completely filled in by the funeral director. F. 25. Was case referred to medical examiner? 26. Place of Death Check onl one Be Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 2No 1 Inpatient 3□ DOA 1 Tyes 2 ER/Outpatient ၉ 28a. Date of Injury (Month, Day Year) 28b. Time of 28d. Describe how injury occurred 27. Manner of Death 28c. Injury at Work? Certification: Injury 1 Matural 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 Suicide determined 4 Homicide 🔝 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifie cause of death (Item 23a) (Type, Print) 30. Name and address of person who ca UZZU Dayna Anne Finkenzeller 31. Date filed (Month, Day, Year) 32. Reastrar's Signature State **JAN 0 7** Registrar

DHMH 17 Rev 1/2001

			For State Registrar	Stat	e of Ma	ryland / [Departme <i>Certifica</i>			and M		giene Reg. No	2000	42540	0
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	Funeral Director		5. Social Security Number	6. Sex 1 \(\text{M} \) 2 \(\text{L}		,	Yrs. Month		Hours	Min.	8. Date of Birl (Month, Da	y, Year)	Co	thplace (State or Foreig ountry)	Įn
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	within 72 hours after death with the Maryland glene. er than "natural", or items 23a or 28a-f sho er the Medical Examiner must be notified at	Funeral Director	1400 Pleasant V	alley Dr.					212	228			U.	S.A.	
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Division of Vital Records,	r Att fter d irects n by t	erti		Could not be letermined 28e. I	Place of Injur building, etc.	y - At home, far (Specify)	m, street, fact	ory, office			28f. Location (S City or Tox			ural Route Number,	
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	To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completed filled in by the funeral director, page 2 should be detached for use as the burial-transit	Medical Certificate:	(Check 2 Med	tifying Physician: To lical Examiner: On the	ne basis of exa	amination and/o	r investigation,	in my opinio	on, death or	ccurred at	the time, date a	and place	e, and due to the	cause(s) and manner sta	ate
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			30. Name and address of pe	erson who completed	cause of dea	ath (Item 23a)	Type, Print)	~	170	<u> </u>		1	4/19	101	_
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DHMH 17 Rev 7/2009

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Month Paul Burton Eichelberger 5:09 A^M December 2009 Medical 4a. Facility Name (if not institution, give street and number, 4b. City. Town, or Location of Death 4c. County of Death Examiner N/A Johns Hopkins Bayview Medical Ctr. Baltimore City Social Security Number If Under 1 Year If Under 24 Hrs. Age (In yrs. last birthday) 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** (Month, Day, Sept. Months Days Hours Min. Country) Maryland 1 🔯 M 2 🗌 F Director 1938 213-36-3070 Usual Residence of Decedent show 10a. State 10b. County 10c. City, Town or Location permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland ms 23a or 28a-f shomust be notified at 10d. Inside City Limits Director 1 Yes 2 X No Dunda1k MD Baltimore 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? by Funeral 21222 3403 Courtway United States ral", or items ? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 12. Was Decedent Ever in U.S 14. Race - American Indian. Armed Forces Black, White, etc. 1 Never Married 2 Married 2 No Yes, Give Baltimore, Maryland 21215-0036 1 Yes 2 X No Specify: "natural", Year or Dates. 1959-62 Completed 3 Widowed 4 Divorced White nt of Health and Mental Hygiene.
If item 27 is marked other than "natur or other traumatic event, the Medical I 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business Industry (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) Steel Industry 2 Years Boiler Operator Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ည Lillian Granruth Samuel D. Eichelberger Wife 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 3403 Courtway Dundalk, Maryland 21222 19a. Informant's Name/Relationship (Type, Print) Mrs. Elizabeth S. Eichelberger 20a Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 1 ☐ Burial 2 🔀 Cremation 3 ☐ Removal from Department of Important: If any injury or 4 ☐ Donation 5 ☐ Other (Specify) Hil/Itop Service Corp; 1/4/2010 Towson, Maryland 22. Name and Address of Facility
Duda-Ruck Funeral Home of Dundalk,
Dundalk, Maryland 21. Signatur of Funeral Say ica License Part 1. Enter the disease, or complications that caused the fleath. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Frysician/ enocurcin disease or condition resulting in death) Medical Due to (or as a consequence of) Examiner Sequentially list conditions, cause. Enter Underlying Cause (Disease or linjury Due to for as a consequence of Exami bunial-tran that initiated events Due to (or as a consequence of) resulting in death) Last this certificate has been signed by the attending physician al director, page 2 should be detached for use as the burial Physician/Medical Hospital or Attending Physician: The law requires that the death certificate be P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery Ectopic pregnancy in the past 12 months? Month 5 Other (specify) Year Pregnant at time of death 2 No 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Division of Vital Records, 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performe 1 Yes 2 No Yes 25. Was case referred to medical funeral director, Be 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 No 2 1 🗌 Inpatient 2 🕰 ER/Outpatient 3 🗀 DOA Certificate: Manner of Death 28a. Date of injury 28b. Time of 28c. Injury at 28d. Describe how injury occurred within 24 hours after death.

To the Funeral Director: After completed filled in by the funer. Natural (Month, Day, Year) 5 Pending 1 ☐ Yes 2 ☐ No Accident Investigation 3 Suicide 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined

DHMH 17 Rev 7/2009

State

Registrar

Medical

29a. Certifier

only one)

29b. Signature and title of certifie

31. Date filed (Month, Day, Year)

JAN 07

30. Name and address of person who completed cause of death (Item 23a) (Type, Print) KEUIN Schendel IVD 9114 Philadelpha RD.

Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29d. Date signed (Month, Day, Year)

300

WD 21237

29c. License number

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Month Year Eggleston Erma Jean 2009 0855 Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death N/A Union Memorial Hosp Baltimore . Social Security Number If Under 1 Year If Under 24 Hrs. Age (In yrs. last birthday) 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** (Month, Day, Year) 236-54-3174 1 □ M 2 🖵 F Months Days Hours Min. Director W.VZ 78 1931 Usual Residence of Decedent show 10b. County 10a. State 10c. City, Town or Location ms 23a or 28a-f sho must be notified at 10d. Inside City Limits Director MD N/A Baltimore 1 ¥ Yes 2 ☐ No 10e. Street and Number 10f. Zip Code 10q. Citizen of What Country? Completed by Funeral 1302 E. 33rd St. 21218 U.S.A. "natural", or items . Was Decedent Ever in U.S Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian. Black, White, etc. 1 Never Married 2 Married 1 Yes 72 hours after Maryland 21215-0036 1 ☐ Yes 2 ☐ No Specify. SpecifyBlack 3 Widowed 4 □ Divorced Year or Dates other traumatic event, the Medical 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) nd Mental Hygiene. marked other than Elementary/Seconday (0-12) 12th College (1-4 or 5+) N/A Housewife Home Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) မ Boyd Ferguson should be Nannie Lee Davison Department of Health an Important: If item 27 is n any injury or other the and is m 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 3923 Lyndale Ave. Baltimore, MD 21213 Kim McAdoo /daughter Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 → Burial 2 □ Cremation 3 □ Removal from State 4 □ Donation 5 □ Other (Specify) Meadow Haven Mem 1/7/10 Ingram W.Va. 22. Name and Address of Facility Beverly D. CromartieF/s Signature of Euperal Service Licensee contacte 2700 Edmondson Ave. Balto, Md. 21223 Fart 1. Entire the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Due to (or as a sequence of): Physician/ disease or condition Medical resulting in death) Examiner if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury that initiated events Due to (or as a consequence of): attending physician and for use as the burial-transit Exam Smokins resulting in death) Last Due to (or as a capsequence of) Physician/Medical IF FEMALE: yes, outcome of pregnancy
Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ____ in the past 12 months? signed by the atte Month Pregnant at time of death 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an certificate has autopsy perform 1 ☐ Yes 2 ☐ No 25. Was case referred to medical funeral director, 읆 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) ျှ 1 🗆 Yes Inpatient 2 ER/Outpatient 3 DOA After this 27. Manner of Death Hospital or Attending Pl 24 hours after death.
 Funeral Director: After the 28a. Date of injury 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred 1 Natural (Month, Day, Year) 5 Pending 1 Yes 2 No Accident Investigation the 3 Suicide
4 Homicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) completed filled in by determined Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. within 24 h Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 3 🗆 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one) 29b. Signature and title of certifie

State

DHMH 17 Rev 7/2009

68760

Box (

P.0.

Records,

Division of Vital

Registrar

Louis E. Kovacs

31. Date filed (Month, Day, Year)

32. Registrar's Signature

201

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

29c. License number

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. Amend Items 25,27,28a-1 per me, 8899,01/06/10dnb Mental Hygiene For A State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Day Physician/ 16.06 pm JACOBO TRENDA 2009 NOVEMBER Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** JOHNS HOPKINS BAYVIEW TIMOR MEDICAL CENT 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs 8. Date of Birth 9. Birthplace (State or Foreign Funeral 1 □ M 2 🖾 F Months Days Hours 08/11/1970 219-88-3169 Maryland 39 Director Yrs. Usual Residence of Decedent permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at 10b. County 10c. City, Town or Location 10d. Inside City Limits Director Maryland N/A Baltimore 1 X Yes 2 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Completed by Funeral 5949 St. Regis Road 21206 United States 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Black, White, etc. 1 Never Married 2 ☐ Married 1 ☐ Yes 2 ☐XNo If Yes, Give Baltimore, Maryland 21215-0036 American Indian 1 ☐ Yes 2 🛣 No Specify: 3 Divorced 4 Divorced Year or Dates 15. Decedent's Education 16a Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) 12 Never Worked N/ABe 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ပ George H. Jacobs Dosha Lee Barton 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Reneice Ramsay - Sister 202 Poplar Avenue Glen Burnie, Maryland 21061 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place)
Hopewell Cemetery 20c. Location - City or Town, State 1 🗴 Burial 2 🗆 Cremation 3 🗆 Removal from State 11/09/2009 Rolland, North Carolina 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee 22. Name and Address of Facility David J. Weber Funeral Homes P.A. 401 S. Chester Street Baltimore, Maryland 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or inspiratory arrest, shock, or heart failure. Let only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ RESPIRATORY FAILURE disease or condition resulting in death) mondes Medical Due to (or as a consequence of) Examiner HOURS SURDURAL Sequentially list conditions, Examine if any, leaving to immediate cause. Enter Underlying Cause (Disease or linjury Due to for as a consequence of APPROVED BY MEDICAL EXAMINER ate has been signed by the attending physician and page 2 should be detached for use as the burial-transit that initiated events Due to (or as a consequence of): NOITA. resulting in death) Last CERTI Physician/Medical F23 α ρ +I+C χ +LDivision of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant in the past 12 months?

1 Yes 2 No 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ Month Day Year 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Certificate: To Be Completed by 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown 24a. Was an 24b. Were autopsy findings available prior to completion of cause of autopsy performe death? certificate 1 1 ☐ Yes 2 ☐ No Yes To the Funeral Director: After this certifics completed filled in by the funeral director, 25. Was case referred to medical 26. Place of Death (Check only one) examiner? 1 Inpatient 2 I ER/Outpatient 3 I DOA 4 Nursing Home 5 Residence 6 Other (Specify 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred work? 1 ☐ Yes 2 X No Subject tripped & fell in bathroom Natural 5 Pending 11/03/2009 2 X Accident **Unknown**^M Investigation Suicide Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4940 Eastern Avenue Baltimore, MD 4 Homicide determined **Hospital** Hospital within 24 hours a To the Funeral I Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a Certifier 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check Certifying Nurse Practionar: To the best of my knowledge, death or diet the tions, determine black and due to this reunals) and manner as stated 29b. Signature and title of certifier 29c, License number 29d. Date signed (Month, Day, Year) RES-OD NOVEMBER

Registrar
DHMH 17 Rev 7/2009

State

4940 EASTERN

AVENUE

RALTINORE MD 2130

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

ATTIMER

32. Registrar's Signature

-A KOHMI

B1. Date filed (Month, Day, Year)

JAN 0 6 2010

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. 1- For Amend Items 25,27,28a-Typer me, graph of the Amend Mental Hygiene Registrar Reg. No. 2 Date of Death
 Month 1. Decedent's Name (First, Middle, Last) Dav Year **Physician** Beulah Keenan 19 15 PM L. 25 2009 12 /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death Examiner Baltimor HOSPITCEL Rosedale FRANKLIN SQUATE If Under 1 Year | If Under 24 Hrs. 9. Birthplace (State or Foreign Country) Maryland 8. Date of Birth (Month, Day, Year) 7. Age (In yrs. last birthday) Social Security Number 220–01–1848 **Funeral** Months Days Hours 1 □ M 2√2 F 92 Director July 23,1917 Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 10a. State 10h Counts 28a-f show If item 27 is marked other than "natural", or items 23a or 28a-f show or other traumatic event, it is Marical Experiment to multifact at Baltimore Dundalk 1 ☐ Yes 2 No Md. Director 10e. Street and Numbe 10f. Zip Code 10g. Citizen of What Country? 21222 USA 8212 Peach Orchard Road Funeral 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 11 Marital Status 72 hours after 1 ∐Yes 2 **X**No If Yes, Give Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 🔯 No Specify: White ģ 3√ Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Department of Health and Mental Hygiene. Important: If item 27 is marked other any injury or other training. 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Housewife Own Home 10 years 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Ernest Ford Anna Ford ပ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a, Informant's Name/Relationship (Type, Print) 8210 Cornwall Road, Dundalk, Maryland 21222 Melanie Fluck Daughter 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State December 20a. Method of Disposition 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State Baltimore City, Md. Holy Redeemer Cem. 4 □ Donation 5 □ Other (Specify) 30, 2009 22. Name and Address of Facility 21. Signature of Funeral Service Licensee, Connelly Funeral Home Of Dundalk, P.A. 7110 Sollers Point Road, Dundalk, Md.21222 23a. Part 1. Enter the disease, a complications that caused the death. on on enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician Congestive
Due to (or as a consequence of): HearT disease or condition resulting in death) /Medical Examiner Sequentially list conditions, if cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to or as a consequence of HON APPROVED BY MEDICAL EXAMINER Hospital or Attending Physician: The law requires that the death certificate be executed attending physician and for use as the burial-transit CERTIFIC Due to (or as a consequence of): P.O. Box 68760, Physician/Medical IF FEMALE 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year ed by the a 9 Unknown been signed by should be detact Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ð 2 No 3 Probably 4 Unknown 1 ☐ Yes racture sp Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has le 2 s autopsy performed? 1 □ Yes 2 ☑ No certificate 2 □No Division of Vital 1 □ Yes : After this certifical funeral director, p 25. Was case referred to medical examiner?
1 🔊 Yes 2 Be 26. Place of Death (Check only one) Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) Certification: To 28a. Date of Injury (Month, Day, Year) 12/18/2009 28b. Time of Injury **p**Unknown M 27. Manner of Death 28d. Describe how injury occurred 28c. Injury at Work? 5 Pending investigation - Natural Subject fell 1 □Yes 2 No 2 X Accident Director: 3 🗌 Suicide 6 Could not be determined 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) Unknown 4 \(\text{Homicide} \) To the Hospital or A within 24 hours after To the Funeral Dire completely filled in b Assisted Living Facility 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) 29b. Signature and 29c. License number 29d. Date signed (Month, Day, Year) le of certifie Hospitalist -28 -2009 Innes Weller, DO H0052024 ss of person who completed cause of death (Item 23a) (Type, Print) FRANKLIN SQUASE DR 9000 Balto md James Welker 32. Registrar's Signature State

Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

amend item 30 per dyr 8899 1-7-10 yt
State of Maryland / Bepartment of Health and Mental Hygiene

		-	For State Registrar	tate of Marylan		tificate of Dea		Reg.		42545
	Physicia	n/	1. Decedent's Name (First, Middle, Last)	Robert Geo	rge K	oerner		2. Date of Death Month Day Ye		3. Time of Death 9:35 P M
	Medic Examin		4a. Facility Name (if not institution, give stree		4b. City, Town, or Location of Death			December	24 2009 4c. County of Death	
-1			1539 North Stepney	Road 7. Age (In yrs. la	et hirthday)	Aberdeen		8. Date of Birth	Harford	place (State or Foreign
	Funeral Director		183–12 – 3495	2 □ F 87	Yrs.		lours Min.	(Month, Day, Year Jan. 23,	1922 Per	ntry) insylvania
	and show lat	or	Usual Residence of Decedent 10a. State 10b. County	10c. City	, Town or Lo	cation				10d. Inside City Limits
	Maryli 28a-f otifiec	Director	MD Harford			A1	berdeen			1 Yes 2 TXNo
	th the	ral D	10e. Street and Number	-		10f. Zip Code	0.1	10g.	Citizen of What Cou	
	eath wi	Funeral		Vas Decedent Ever in U.S	3. 13. V	2100 Vas Decedent of Hispa Tyes, specify Cuban, M		ify Yes or No-	United St	
9036	be filed within 72 hours after death with the Maryland ental Hygiens ked other than "natural", or items 23a or 28a-f sho ked other than "natural", or items 25a or 28a-f sho ic event, the Medical Examiner must be notified at	þ	1 Never Married 2 Married	Armed Forces? Yes 2 No f Yes, Give /ear or Dates. 1942	_ _	f Yes, specify Cuban, M ☐ Yes 2 🔀 No S		ican, etc.)	Black, White,	etc. iite
15-(72 hou n "nat	Completed	15. Decedent's Educat (Specify only highest grade c		(Give I	lent's Usual Occupation kind of work done durin O NOT use retired)		7	. Kind of Business Ir .ltimore (
212	within giene. er thai		Elementary/Seconday (0-12) 8 Years	College (1-4 or 5+)		stodian			. of Educ	-
pu	e filed ttal Hy ed oth event	To Be	17. Father's Name (First, Middle, Last)			18	,	First, Middle, Maide	ŕ	
13	should be file and Mental I is marked o raumatic eve		Herbert Koerner 19a. Informant's Name/Relationship (Type, F	rint)	10h Mailin	ig Address (Street and			stermaker	
, Ma	and 2 sho Health an tem 27 is		Joan Koerner Ex	-Wife		9 N. Stepne				
Baltimore, Maryland 21215-0036	age 1 ent of nt: If ii		20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ Rem 4 ☐ Donation 5 ☐ Other (Specify)	oval from State	emetery, cren	sition (Name of natory or other place) Service Co	rp. 12/3		Location - City or Towson, Ma	
Balt	permit. P Departm Importa any inju	إ	21. Signature of Funeral Service Licensee	20		Name and Address of uda-Ruck Fu 1922 Wise A				nc. 1222
	nysician/	2 T.S	23a. Part 1. Enter the disease, or complicat shock, or heart failure. List only one ca Immediate Cause (Final disease or condition	ons that caused the death use on each line.	n. Do not ente					Approximate Interval Between Onset and Death
	Medical Examiner		resulting in death)	Due to (or as a consequ		· olary	- Will	21		
	ed sit	Examiner	Sequentially list conditions if any, leading to immediate cause. Enter Underlying Cause (Disease or linjury	Due to (or as a consequ	ence of):					
4	icate be executed physician and s the burial-transit	cal Exa	that initiated events resulting in death) Last	Due to (or as a consequ	ence of):					
8760	ificate ig phys as the	Medical	IF FEMALE:							
Box 6		Physician/I	23b. Was decedent pregnant in the past 12 months?	f yes, outcome of pregnan ☐ Live Birth 2☐ Feta ☐ Pregnant at time of c ☐ Unknown	Ideath 3	Ectopic pregnancy Other (specify)			23d. Date of deliv Month	very Day Year
ds, P.O.	quires that the series and be detacted by	ρ	Part II. Other significant conditions contrib	1	ulting in the u	nderlying cause given i	in Part I.		o use contribute to	the cause of death?
Division of Vital Records,	s ician: The law rec certificate has be: irector, page 2 shc	Completed				•		24a. Was an autopsy performed 1 \(\sumeq\) Yes 2	prior to co	opsy findings available ompletion of cause of
<u>ta</u>	ysician: is certific director,	Be	25. Was case referred to medical examiner? 1 ☐ Yes 2 🗓 No	tal:		Other	of Death (Check of	1/		
on of V	Phy this ald	icate: To		8a. Date of injury (Month, Day, Year)	ury 28b. Time of 28c. Injury at 28d. Describe how injury occurred					
Jivisio	spital or Attending I ours after death. eral Director: After filled in by the funer	Certificate:	3 Suicide 6 Could not be	8e. Place of Injury - At ho building, etc. (Specify,		eet, factory, office	25	8f. Location (Street City or Town, Sta	and Number or Rura ate)	al Route Number,
	To the Hospita within 24 hours To the Funera completed fille	Medical	29a. Certifier (Check only one) 3 Certifying Physician Certifying Physician Certifying Physician Certifying Nurse Pr	On the basis of examination	and/or invest	igation, in my opinion, d	death occurred at the	he time, date and pla	ice, and due to the c	ause(s) and manner stated.
1	To th withii To th comp		29b. Signature and ittle of certifier	fin		29c. License nui	4./		Date signed (Month,	
			30. Name and address of person who comp	eted cause of death (Item	23a) (Type, P	rint) St C	2011	PL #L	109	
ï	Stat Registra		31. Date filed (Month, Day, Year) JAN 0 7 2010	32. Registrar's Sign	ure	elg. m	and a			

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Year **Physician** E 0 /Medical 4a. Facilly Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Silver Spring If Under 1 Year If Under 24 Hrs. Montgomery County

G. Birthplace Grate or Foreight
ar)

Country Social Security Number 7. Age (In yrs. last birthday, 8. Date of Birth (Month, Day, Year) **Funeral** Hours 1 □ M 2 2 248-16-9652 Usual Residence of Decedent onway Director 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits 28a-f show permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryla Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "natural", or Items 23a or 28a-f show any Injury or other traumatic event, the Medical Examination or other traumatic event, the Medical Examination or other traumatic event, the Medical Examination 1 Yes 2 □ No Director 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number 2001 Funeral I 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 11. Marital Status 1 ☐ Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 1 □Yes 2 No Specify Specify: ģ 3 Widowed 4 □ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) Govern ment Highschool 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be (Evans Ella Bowman ပ (SON) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) Amapolis Michae 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 1 ☐ Burial 2 Cremation 3 ☐ Removal from State Riverdale, MP 4 □ Donation 5 □ Other (Specify) 4809 Georgia auzini 21. Signature of Funeral Service Licensee 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shocks, or least failure. List only one cause on each line. Washington, DC 20011 Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** ATTAC ereprai 3 day 5 disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner b. Atheroscierosi Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to (or as a consequence of) law requires that the death certificate be executed and burial-trar Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, attending physician Physician/Medical as the I IF FEMALE: for use a 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months?
1 □ Yes 2 No Month Year Day 4 ☐ Pregnant at time of death 5 ☐ Other (specify) the 9 ☐ Unknown 9 Unknown ģ signed I Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? \$ 2 No 1 Tes 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has autopsy After this certificate 2 **X** No 1 ☐Yes 2 ☐ No 1 ☐ Yes Hospital or Attending Physician: 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA မှ 27, Manner of Death 1 Natural 2 ☐ Accident Date of Injury (Month, Day, Year) 28b. Time of Injury 28c. Injury at Work? 28d. Describe how injury occurred Certification: 5 ☐ Pending investigation n 24 hours after death.

le Funeral Director: Aft
bletely filled in by the fun 1 ☐ Yes 6 ☐ Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

| Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) Medical 29a, Certifier (Check only one) and manner stated. within 2 To the 29d. Date signed (Month, Day, Year)

State Registrar 29b. Signature and title of certifier

31. Date filed (Month, Day, Wear)

JAN 07

Georgia

2010

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 2009 42547 1 - For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death December 30, 2009 **Physician** Andrew Terrell Leak, 3rd 8:12a.M /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner ST. AGNES HOSPITAL BALTIMORE N/A If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 7. Age (In yrs. last birthday, 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** 1√2M 2□ F Hours 215-13-0806 Director 41 Sept.19,1968 Maryland Usual Residence of Decedent death with the Maryland 10c. City, Town or Location 10b. County 10d. Inside City Limits 10a. State 28a-f show 1 ☐ Yes 2 ☑ No Director MarylandBaltimore Windsor Mill 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 10 W. Bend Court t Apt. A

12. Was Decedent Ever in U.S. Armed Forces? Funeral 14. Race - American Indian, 11. Marital Status permit. Pages 1 and 2 should be filed within 72 hours after c Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or iten any injury or other traumatic event, the Medical Examiner. once. Black, White, etc. 1 Yes 2 No
If Yes, Give
Year or Dates: 1 ☐ Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☐ No Specify. Specify: þ 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) Self Employed Home Improvement 12th grade 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Andrew T. Leak, Jr. Margaret Burch 2 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 21244 <u>LaKessia Leak/ Wife</u> 10 W. Bend Court. Apt. A Windsor Mill, MD 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1/7/2010 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State Woodlawn, Maryland King Memorial Park 4 Donation 5 Other (Specify) 22. Name and Address of Facility Chatman-Harris Funeral Home 5240 Reisterstown Rd Baltimore, MD 21215 arris 3a. Part. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, suck, or hear failure. List only one cause on each line. Approximate Interval Between Onset and Death mediate Cause (Final Physician END - STAGE RENAL DISEASE 2 YEARS disease or condition resulting in death) Medical Due to (or as a consequence of): Examiner ARTERIONEPHROSCLEROSIS YEARS Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to for as a consequence off Examine HUPERTENSIVE CARDIOVASCULAR DISEASE YEARS The law requires that the death certificate be executed Due to (or as a consequence of) physician a Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month 5 ☐ Other (specify) 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ð CARDIOMYOPATHY ASTHMA 1 ☐ Yes 2 No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of 24a. Was an performed? death? 2 □ No 2 No 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 No After this of ဥ 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28d. Describe how injury occurred 28c. Injury at Work? Certification: 1 Natural 2 ☐ Accident 5 Pending investigation 1 ☐ Yes 2 ☐ No Director 6 Could not be determined 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 ☐ Homicide To the Funeral C

Records, レEAK / Division or Vital To the Hospital or Attending Physician: 24

State Registrar

DHMH 17 Rev 1/2001

29a. Certifier (Check only

29b. Signature and title of certifier

KRIS M. SHEKITIA MD GOO CATON AVE. BALTIMORE, MD 21229 31. Date filed (Month, Day, Year) 32. Registrar's Signature

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29c. License number

D0037359

29d. Date signed (Month, Day, Year)

Dec. 31, 2009

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death Reg. No. 2 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ DECEMBER 15 2009 1:54 P RTCHARD NWOKE Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death Examiner MONTGOMERY HOLY CROSS HOSPITAL SILVER SPRING Social Security Number If Under 1 Year If Under 24 Hrs. 8 Date of Birth 7. Age (In yrs, last birthday) 9. Birthplace (State or Foreign **Funeral** 1 🖾 M 2 🗆 F Days Min JUNE 6 1946 NIGERIA Yrs Director 217-76-0312 63 Usual Residence of Decedent 28a-f show 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits must be notified at Director 1 🕎 Yes 2 🗌 No PRINCE GEORGE'S HYATTSVILLE MD or 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 23a Funeral 1305 MADISON STREET 20782 USA 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. Examiner Armed Forces Black, White, etc. "natural", or 1 Never Married 2 X Married Completed by 1 Yes If Yes, Give 72 hours after Baltimore, Maryland 21215-0036 Specify: BLACK 1 Yes 2 XNo Specify: 3 Widowed 4 Divorced Year or Dates event, the Medical 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) and Mental Hygiene. is marked other than Elementary/Seconday (0-12) College (1-4 or 5+) 5+ ESTATE AGENT PRIVATE Be 17, Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) permit. Page 1 and 2 should be fil Department of Health and Mental Important: If item 27 is marked on any injury or other traumatic ew ဂ္ဂ IHEATURU NWOKE KEKE ESTHER 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) ETHEL NWOKE/WIFE 1305 MADISON STREET HYATTSVILLE, MARYLAND 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State 1 N Burial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify) cemetery, crematory or other place FAMILY PLOT OBOWO, NIGERIA 02-13-2010 J. B. JENKINS FUNERAL HOME 21. Signature of Funeral Service Licensee 22. Name and Address of Facility 7474 LANDOVER ROAD LANDOVER, MARYLAND 20785 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ BRAIN EDEMA disease or condition resulting in death) Medical Due to (or as a consequence of) Examiner ACUTE STROKE Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or linjury Due to (or as a consequence of) Examir that the death certificate be executed as the burial-transit HYPERTENSION that initiated events resulting in death) Last and Due to (or as a consequence of): attending physician Physician/Medical CORONARY ARTERY DISEASE yes, outcome of pregnancy
Live Birth 2 Fetal death nse 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? ò Pregnant at time of death 5 Other (specify) Month Day Year detached g Unknown þ been signed the should be detailed Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by Hospital or Attending Physician: The law requires 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 💢 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? Yes 21 No 1 Yes within 24 hours after death.

To the Funeral Director: After this certific completed filled in by the funeral director, Be 25. Was case referred to medical 26. Place of Death (Check only one) examiner? 2 🔀 No 1 Inpatient 2 ER/Outpatient 3 DOA 잍 4 Nursing Home 5 Residence 6 Other (Specify) 27. Manner of Death 28a. Date of injury (Month, Day, Year) Certificate: 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 Natural 2 Accident 3 Suicide iniury 5 Pending work? 1 Yes 2 No Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Medical

of Vital Division To the I within 2

Box 68760

P.O.

Records,

10 V

31. Date filed (Month, Day, Year) State Registrar

29a. Certifier

only one 29b. Signature and title

30. Name and addre

1500 FOREST GLEN ROAD SILVER SPRING, MARYLAND M.D. DELROY ANGLYN

1 😾 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29d. Date signed (Month, Day, Year)

DECEMBER 16, 2009

29c. License number

D55148

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month Year **Physician** en :05 PM 2009 ecember 1aurice /Medical 4a, Facility Name (If not institution, give street and number) County of Death 4b. City, Town, or Location of Death **Examiner** Hospice of The Chesapeake inthiaum ANNE If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, 5. Social Security Number 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign **Funeral** 12 M 2□ F Months Days 213-26-6058 Director Usual Residence of Decedent Pages 1 and 2 should be filed within 72 hours after death with the Maryland nent of Health and Mental Hygiene. ant: If Item 27 Is marked other than "natural", or Items 23a or 28a-f show 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits ral", or Items 23a or 28a-f show Examiner must be notified at 1 dyes 2 □ No Director nmore 10f. Zip Code 10e. Street and Number 10g. Citizen of What Country? 2122 Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ★ Yes 2 □ No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian 11. Marital Status Black, White, etc. 1 ☐ Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No þ Specify: 3 Widowed 4 ☐ Divorced Completed 27 Is marked other than "natur traumatic event, the Medical 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use <u>retire</u>d) Elementary/Secondary (0-12) College (1-4or 5+) 17. Father's Name (First, Middle, Last, 18. Mother's Name, (First, Middle, Maiden Surname) Be ၉ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) deheme MD 21229 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory pr other place) Date Department of I Important: If Ite any Injury or of once. Burial 2 ☐ Cremation 3 ☐ Removal from State adowned9 4 □ Donation 5 Other (Specify) 22. Name and Address of Facility f Funeral Se vices 207 Approximate Interval Between Onset and Death 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause an ach line. ediate Cause (Final ase or condition Immediate Cause (Final disease or condition resulting in death) **Physician** acla JEA! /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): The law requires that the death certificate be executed burial-transit and Due to (or as a consequence of): Box 68760, attending physician Physician/Medical the as IF FEMALE: nse 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d Date of delivery 3 Ectopic pregnancy ō in the past 12 months? Month Day Year 5 Other (specify) P.0. signed by the a ☐Yes 2☐No 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? of Vital Records, 2 1 🗌 Yes 3 ☐ Probably 4 ☐ Unknown Completed peen 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an page 2 s has autopsy certificate 1 □ Yes 2 No 1 TYes To the Hospital or Attending Physician: Within 24 hours after death.

To the Funeral Director: After this certificat completely filled in by the funeral director, p 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) 1 Yes No Hospital: Other: 1 Inpatient 2 ER/Outpatient 3 DOA Certification: To 4 Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 105 28a. Date of Injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Division 1 Natural 2 Accident 5 Pending investigation 1 □Yes 2 □No 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 29a, Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) Medical and manner stated 29b. Signature and title of certified 29d. Date signed (Month, Day, Year) 29c. License number 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) St. South Hano Hanover

Registrar

State

31. Date filed (Month, Day, Year)

Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 2 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month PRUDENCE QUANSAH 2107 PM December 2009 Ž8 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death The Johns Hopkins Hospital **Baltimore City** 5. Social Security Number If Under 1 Year If Under 24 Hrs. Months Days Hours Min. 8. Date of Birth (Month, Day, Year) 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) 1 🗆 M 2 🕟 219-33-5129 Usual Residence of Decedent 10b. County 10c. City, Town or Location 10d. Inside City Limits Yes 2 No tomore 10e. Street and Number 10f. Zip-Code 10g. Citizen of What Country? Was Decedent Ever in U.S. Armed Forces 13. Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Race - American Indian, Black, White, etc. 1 Never Married 2 Married 1 ☐ Yes 2 No If Yes, Give Year or Dates: 1 ☐ Yes 2 No 3 Widowed 4 □ Divorced Specify: 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business/Industry (Specify only highest grade completed) Elementary/Secondary (0-12) College (4-4 or 5+) Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname 19a. Informant's Name/Relationship (Type. 19b. Mailing Address (Street and Number or 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 Surial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify) Funeral Service License MD 20Th 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) sepsis Due to (or as a consequence of): Due to (or as a consequence of) Due to (or as a consequence of) 23c. If yes, outcome of pregnancy 1 \square Live birth 2 \square Fetal dea 23d. Date of delivery 2 Fetal death 3 - Ectopic pregnancy Day Pregnant at time of death Year 5 Other (specify) 9 Unknown 23e. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death?

Physician /Medical **Examiner**

Physician

/Medical

Examiner

10a, State

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Funeral

Director

28a-f show

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or items 23a

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Important; If ite
any injury or ott

Funeral Director

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Completed

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Pages 1 and 2 should be filed within 72 hours after death with the Maryland nent of Health and Mental Hygiene.

Baltimore, Maryland 21215-0036

attending physician I Director: After to in by the funeral within 24 hours a

To the Funeral C

completely filled

Hospital or Attending Physician; The law requires that the death certificate be executed

Division of Vital Records, P.O. Box 68760,

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Viscass or injury) Examiner that initiated events resulting in death) Last Physician/Medical IF FEMALE: 23b. Was decedent pregnant in the past 12 months? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 2 Completed 24a, Was an autopsy performed? Yes 2XNa 25. Was case referred to medical Be 26. Place of Death (Check only one) Hospital: 1 Tes 2**X** No Other: 4 - Nursing Home 1 XInpatient 3 🗆 DOA ၉ 2 ER/Outpatient 5 Residence 6 Other (Specify) 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? Certification: Time of 28d. Describe how injury occurred 1 XNatural 5 Pending investigation Injury 2 □ No 2 Accident 1 Yes 3 Suicide 6 Could not be Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number. determined 4 - Homicide City or Town, State) Example 1 Example 2 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical (check only 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year)

State Registrar

30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Katherine Thomas

600 North Wolfe St, Baltimore, MD, 21287

Acember 28, 2009

2 No

1 TYes

31. Date filed (Month, Day, Year)-

atherine c

RES - 000

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. 1- State of Maryland / Department of Health and Mental Hygiene me, 8898,12723709dhb

Certificate of Death

Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Month Charles Carter Schnetzler 2000 Dec 6:58p Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death 5671 Vantage Point Columbia Howard Social Security Number Funeral 6. Sex 7. Age (In vrs. last birthday If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign 1 🗓 M 2 🗆 F Months Days Hours Min June 3, Year 1930 511-26-4395 Indiana Director 79 Usual Residence of Decedent r than "natural", or items 23a or 28a-f shov the Medical Examiner must be notified at 10c. City, Town or Location 10a. State 10b. County Director 10d. Inside City Limits Columbia 1 Yes 2 X No Maryland Howard 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 21044 United States 5671 Vantage Point Road 12. Was Decedent Ever in U.S 11. Marital Status 13. Was Decedent of Hispanic Origin? (Specify Yes or No-14. Race - American Indian, Armed Forces's If Yes, specify Cuban, Mexican, Puerto Rican, etc. 1 Never Married 2 🔀 Married Black, White, etc. Ď 1 X Yes If Yes, Give Maryland 21215-0036 1 Yes 2 X No Specify: 3 Widowed 4 Divorced Completed Specify: White Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business Industry (Specify only highest grade completed) other than Elementary/Seconday (0-12) College (1-4 or 5+) 5+ Geochemist NASA other traumatic event, Be 17. Father's Name (First, Middle, Last) should be file and Mental F is marked of 18. Mother's Name (First, Middle, Maiden Surname) ည Harry George Schnetzler Marjorie Wilcox permit. Page 1 and 2 should the Department of Health and Me Important: If item 27 is marthen the Important of 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Beverly Schnetzler/ Wife 5671 Vantage Point Road, Columbia, Maryland 21044 Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State December 16. cemetery, crematory or other place 1 D Burial 2 X Cremation 3 Removal from State injury or 4 Donation 5 Other (Specify) Metro Crematory, Inc. 2009 Baltiomre, Maryland 21. Signature of Juneral Service Licensee 22. Name and Address of Facility Cremation Society of Maryland, Amanda Heaston Int. 299 Frederick Road, Baltimore, Maryland 21228 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Interval Between Immediate Cause (Final Onset and Death Physician espicatocy disease or condition Selvou Medical resulting in death) Due to (or as a consequence of) Examiner 6 dec RAC NEEKs Sequentially list conditions, Examiner cause. Enter Underlying Cause (Disease or linjury that initiated events CERTIFICATION APPROVED BY MEDICAL EXAMINER and Due to (or as a consequence of): resulting in death) Last ed by the attending physician detached for use as the buria Physician/Medical To the Hospital or Attending Physician: The law requires that the death certificate be within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending obysicis IF FEMALE: nse 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 3 ☐ Ectopic pregnancy 23b. Was decedent pregnant 23d. Date of delivery in the past 12 months? Day 4 Pregnant 9 Unknown 5 Other (specify) Pregnant at time of death Month Year Yes 2 🗌 No 9 Unknown been signed by Part II, Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by DEGENELATIVE Division of Vital Records, 1 ☐ Yes 2 No 3 ☐ Probably 4 ☐ Unknown HYPERTENSION 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy this certificate HUPERLIPDEMIN performed 2 XN Yes 2 No director, 25. Was case referred to medical Certificate: To Be 26. Place of Death (Check only one) examiner? Hospital: 2 2 No Other: 1 Inpatient 2 I ER/Outpatient 3 I DOA 4 Nursing Home 5 Nesidence 6 Other (Specify) funeral 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred Natural 5 Pending work? 1 ☐ Yes 2 🛣 No Subject pedestrian struck by 11/04/2009 8:33 p M Investigation 6 Could not be Accident filled in by the a car 3 Suicide 4 Homicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) **Roadway** 28f. Location (Street and Number or Rural Route Number City or Town, State Little Patuxent Parkway near Colubia Rd., MD 29a. Certifier 1 Acertifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as state Columbia Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certifier 29c. License number 122856

DHMH 17 Rev 7/2009

State Registrar 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Year)

31. Date filed (Month, Day,

DFC.

The PATURENT Hey

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. Amend #18 per FH G899 1/19/10 TT State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician /Medical illty Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Surity Number 8. Date of Birth If Under 1 Year 9. Birthplace (State or Foreign **Funeral** dast birth 1 2 M 2 □ F Months Days Hours Min Country) PAR HAVIE Director Usual Residence of Decedent the Maryland 10c. City, Town or Location 10d. Inside City Limits 10a. State 10b. County ral", or items 23a or 28a-f show Examiner roust be notified at Yes 2 No Director 10g. Citizen of What Country 10e. Street and Number 10f. Zip Code Pages 1 and 2 should be filed within 72 hours after death with iment of Health and Mental Hygiene.

ant: If Item 27 is marked other than "natural", or items 23a or ury or other traumatic event, the Medical Examination and being or other traumatic event, the Medical Examination is ust being the modical Examination and being or other traumatic event. 638 Completed by Funeral 12. Was Decedent Ever in U.S Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Black, White, etc. 1 □Yes 2 → No 1 Never Married 2 Married Baltimore, Maryland 21215-0036 If Yes, Give Year or Dates 1 ☐ Yes 2 ☐ No Specify. Specify: 3 Widowed 4 ☐ Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Elementary/Spendary (0-12) College (1-4or 5+) 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be ည Anna Hostler Informant's Name/Relationship 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 10a 10 20b. Plac 20a. Method Disposition of Disposition etery, crematory 20c. Location - City or Town, State Date 3 Removal from State 1 Burial 2 ☐ Cremation permit. Page Department of Important; If any Injury or once. 5 Other (Specify) 4 ☐ Donation 21. Signature Funeral Service 22. Name and Address of Facility Approximate Interval Between Onset and Death 23a. Part 1. Enter the disease, or complications that caused the death. shock, or heart failure. List only one cause on each line. Do not enter the mode of dying, such as cardiac or respiratory arrest. Immediate Cause (Final **Physician** VMOR 51 disease or condition resulting in death) year /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit Due to (or as a consequence of): Records, P.O. Box 68760, Physician/Medical IF FEMALE If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 □Yes 2 □ No Month Day Year 5 Other (specify) 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ð 1 ☐ Yes 2 Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy Division of Vital 1 ☐Yes 2 No 1 ☐ Yes 2 No 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner' Hospital Other: 4 ☐ Nursing Home 5 ☑ Residence 6 ☐ Other (Specify) 1 Yes 2 No Certification: To 1 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of Injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 ☐ Accident 6 ☐ Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) Location (Street and Number or Rural Route Number, City or Town, State) determined 4 ☐ Homicide 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) Medical (Check only one) and manner stated. 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) ician 30. Name and address of person who completed cause of death (Ir m 23a) (Type, Print) TURTEIL 4740 JHBUN C MICHAIL IZ. 31. Date filed (Month, Day, Year). 32 State

DHMH 17 Rev 1/2001

Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. Amend Item State of Maryland Department of Health and Mental Hygiene Certificate of Death Reg. No. 1 - For State Registrar 009 42553 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month **Physician** Year hristo ner Lovey DEC AM /Medical 2009 4a. Facility Name (If not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death County wara 5. Social Security Number If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) Funeral 7. Age (In yrs. last birthday) 213-96-6312 Months Days Hours Min 1 ☑ M 2 ☐ F Director 07 Usual Residence of Decedent death with the Maryland 10a. State 10b. County 10c. City, Town or Location ortant; If item 27 is marked other than "natural", or items 23a or 28a-f show injury or other traumatic event, the Modical Examinat has collined at 10d. Inside City Limits Director 1 ☐ Yes 2 No 10e. Street and Number 10g. Citizen of What Country? 12050 21044 Funeral Uxent 12. Was Decedent Ever in U.S. Armed Forces? 1 \(\text{Yes} \) 2 \(\text{No} \) 11. Marital Status Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. Pages 1 and 2 should be filed within 72 hours after nent of Health and Mental Hygiene. Int: If Item 27 is marked other than "natural", or Ite 1 Never Married 2 Married Baltimore, Maryland 21215-0036 If Yes, Give Year or Dates: 1 ☐ Yes 2 ☐ No Specify. 3 3 ☐ Widowed 4 ☐ Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a, Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname Be ames ဂ္ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, permit. Pages 1 and 2:
Department of Health al
Important: If Item 27 is
any injury or other trau Columbia MD21044 20a. Method of Disposition 20b. Place of Disposition (Name of cemptery, crematory of other p 20c. Location - City or Town, State 1 ☑ Burial 2 ☐ Cremation 3 Removal from State -2010 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee 22. Name and Address of Facility a vann C. Greene Funeral Services Pike 13a/to 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or hear failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** ast /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Unvertying Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to (or as a consequence of) burial-tra Physician: The law requires that the death certificate be exec Due to (or as a consequence of) attending physician for use as the buria Box 68760 Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d Date of delivery 3 Ectopic pregnancy in the past 12 months? Day Month Year 5 ☐ Other (specify) P.0. 1 ☐ Yes 2 ☐ No. detached 9 Unknown ò signed I Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Records, Completed by 2 No 3 Probably 4 Unknown filled in by the funeral director, page 2 should 1 ☐ Yes has been 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? Yes 2 No certificate Vital 1 □ Yes 1 ☐ Yes 2 ☐ No 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Hospital: Other: 4 \sum Nursing Home Certification: To 1 ☐ Yes 2 X No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA ō After this 5 Presidence 6 ☐ Other (Specify) 28a. Date of Injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Hospital or Attending Division 1 Natural 5 Pending investigation death. 2 Accident 1 ☐ Yes 2 🗆 No within 24 hours after death To the Funeral Director; 3 Suicide 6 ☐ Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Medical 29a. Certifier completely (Check only one) 29b. Signature and title of certific 29c. License number 29d. Date signed (Month, Day, Year) 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) DV. STE#140 5450 KNOLL NORTH KASAMON

Registrar
DHMH 17 Rev 1/2001

State

31. Date filed (Month, Day, Year)

Registrar's Signature

09-10248 Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. Kathleen Teasley State of Maryland / Department of Health and Mental Hygiene 1- For State Certificate of Death Reg. No. Registrar 2. Date of Death 1. Decedent's Name (First, Middle, Last) Physician/ Month 1704 hrs **Medical Examiner** December 31, 2009 Teasley Kathleen 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Baltimore** 740 Poplar Grove Street # 4A N/A If Under 1 Year If Under 24Hrs. 8. Date of Birth (MM/DD/YYYY 9. Birthplace (State or 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) **Funeral** Months Days Min Hours Director Country) M 2 X F 85 Yrs 02/16/1924 247-36-4609 Usual Residence of Decedent 10d. Inside City Limits any 10b. County 10c. City, Town or Location 1 X Yes 2 No 28a-f show "natural", or items 23a or 28a-f sho I Examiner must be notified at once. N/A Baltimore MD Pages 1 and 2 should be filed within 72 hours after death with the Maryland Director 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 740 Poplar 21215 Apt U.S.A. Grove Funeral 11. Marital Status 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No 14. Race - American Indian, Black, Armed Forces? If Yes, specify Cuban, Mexican, Puerto Rican, etc.) White, etc. Never Married 2 Married 2 X No Yes Specify: Black Yes 2 X No specify: If Yas, Give Year Widowed 4 X Divorced ੬ 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done 16b. Kind of Business/Industry Completed during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) Empire Street event, the Medical MD 21215-0036 If item 27 is marked other than Custodian Building Health and Mental Hygiene. 11th Grade 17. Father's Name (First, Middle, Last) 18.Mother's Name (First, Middle, Maiden Surname) Moore Catherine Bratton Alex 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 21217 <u> Clarence Howell(Nephew</u>) Baker St., Balto., MD 20b. Place of Disposition (Name of cemetery, 20c. Location - City or Town, State 20a. Method of Disposition Date Baltimore, Joseph Brown F/H And Crematory Department of F Burial 2 X Cremation 3 Removal from State 01/07/10 Baltimore, MD Donation 5 Other Specify 22 Name and Address of Facility Joseph H. Brown Jr. Funeral H 2140 N. Fulton Ave., BAlto., MD 21 Signature of Funeral Service Licensee Approximate Interval 23a. Part I Deter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart **Physician** Between Onset and List only one cause on each line 'Medical a. Hypertensive Atherosclerotic Cardiovascular Disease Immediate Cause (Final disease kaminer or condition resulting in death) Due to (or as a consequence of): Sequentially list conditions, Due to (or as a consequence of): if any, leading to immediate cause. Enter Underlying Cause Examine (Disease or injury that initiated Due to (or as a consequence of): events resulting in death) Last and - transit cal UNPENDED AMENDED attending physician for use as the burial Physician/Medi Division of Vital Records, P.O. Box 68760, 23d. Date of delivery IF FEMALE: 23c. If yes, outcome of pregnancy 23b. Was decedent pregnant in the past 12 months? 3 Ectopic pregnancy Live birth Fetal death Month Day Pregnant at time of death 5 Other (Specify) Yes 2 ✔ No 9 Unknown Unknown icate has been signed by the page 2 should be detached for contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ð Yes 2 No 3 Probably 4 ✔ Unknown Completed 24b. Were autopsy findings available 24a. Was an prior to completion of cause of autopsy After this certificate has death? Yes Yes 2 V No 1 2 No funeral director, 25. Was case referred to medical 26.Place of Death (Check only one) To the Hospital or Attending Physician: Be Hospital: 1 Other₄ DOA Nursing Home 5 Residence 6 V Other: Scene Inpatient ER/Outpatient 1 V Yes 28a. Date of Injury (Month, Day, Year 28b. Time of Injury 28c. Injury at Work? 28d. Describe how injury occurred 27. Manner of Death Certification: 1 V Natural Pending Yes 2 No hours after death. the Director: 2 Investigation Accident completely filled in by 28e. Place of Injury - At home, farm, street, factory, office building, etc. 28f, Location (Street and Number or Rural Route Number, City 3 Suicide Could not be or Town, State) within 24 hours at To the Funeral L determined Homicide 29a. Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical 2 📝 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier

OCME 2006

Registrar DHMH 17 Rev 1/2001

State

a

Zabiullah Ali, M.D. 31. Date filed (Month, Day, Year)

30. Name and address of person who completed cause of death (Item 23a)

Assistant Medical Examiner

32. Registrar's Signature

ORIGINAL

O.C.M.E.

111 Penn Street, Baltimore, MD 21201

COME

January 1, 2010

Death

Year

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. Amend Item 25 123 of Maryland & Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Month 1433 **Lamont Thompson** Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death Examiner 4c. County of Death N/A **Baltimore** Union Memorial Hospital 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs 8. Date of Birth 9. Birthplace (State or Foreign Funeral 1 🙀 M 2 🗆 Months Days Hours Min (Month, Day, Jan 7, 1945 Yrs Maryland **Director** 218-42-5905 Usual Residence of Decedent permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hyglene. Important: If item 27 is marked other than "natural" any injury or other traumatic events. 10b. County 10d. Inside City Limits 10a. State 10c. City, Town or Location Director 1 Yes 2 No Baltimore Baltimore Maryland 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 6523 Lehnert Street 21207 U.S.A 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 11. Marital Status 14. Race - American Indian Armed Forces?

1 Yes 2 X No Black, White, etc. 1 Never Married 2 Married þ 1 Yes 2 X No Specify: If Yes, Give Year or Dates Black Specify Completed 3 XWidowed 4 Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) Owner Funeral Home **Funeral Director** Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ည Addie H. Thompson Northern Thompson 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 6523 Lehnert Street Baltimore, Maryland 21207 Lamont Thompson, Jr. 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date cemetery, crematory or other place) 1 X Burial 2 Cremation 3 Removal from State 12/19/09 Windsor Mill, Md. King Memorial Park 4 ☐ Donation 5 ☐ Other (Specify) re of Funeral Service 22. Name and Address of Facility Estep Brothers Funeral Service, P. 1300 Futaw Place Baltimore, Md 21217 Part 1. Enter the disease, or complications that caused the death Do vot enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between On et and Death Immediate Cause (Final Pnysician/ Millisustem Medical resulting in death) Due to (or as consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examine Due to (or as a consequence of) Cause (Disease or iinjury that initiated events resulting in death) Last and the burial-tran Due to (or as a consequence of): attending physician CERTIFICATION AP Physician/Medical the Hospital or Attending Physician: The law requires that the death certificate be 有之のけた Division of Vital Records, P.O. Box 68760 ate has been signed by the attending page 2 should be detached for use as IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 🔲 Ectopic pregnancy in the past 12 months?
1 ☐ Yes 2 ☐ No Month Day Year 5 Other (specify) Pregnant at time of death Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 X Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? Yes 2 (No this certificate has 2 No 1 Yes funeral director, 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) မ 1 🔀 Inpatient 2 🗆 ER/Outpatient 3 🗆 DOA Manner of Death 28a. Date of injury 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred After (Month, Day, Year) injury 1 X)Natural 5 \square Pending 1 Yes 2 No 24 hours after deatle Funeral Director: npleted filled in by the Accident Investigation Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Medical 29a. Certifier 🔀 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, in my opinion, in my opinion of the pass of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check 3 🗆 To the F only one) 29b. Signature and title of certifier 2 29c. License number 29d. Date signed (Month, Day, Year) 09 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Registrar

State

LOVIS

Day, Year)

JAN 06

31. Date filed (Month,

VERS

201

32. Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - State Registrar Certificate of Death Reg. No. 2. Date of Death 1. Decedent's Name (First, Middle, Last) Year **Physician** 1:30 PM 2009 12 hia /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) Town, or Location of Death Examiner hevy Chase Montgomery HS Chevy If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, 9. Birthplace (State or Foreign Country) 6. Sex 5. Social Security Number 7. Age (In yrs. last birthday) Funeral Year) Months Days 1 □ M 2 🕽 F 9 Director Usual Residence of Decedent 10d. Inside City Limits Pages 1 and 2 should be filed within 72 hours after death with the Maryland 10c. City, Town or Location 10h County 10a State or 28a-f show Injury or other traumatic event, the Medical Examiner must be nutified at 1 XYes 2 ☐ No Funeral Director ncise 10f. Zip Code 10g. Citizen of What Country? 10e, Street and Number U.S.A permit. Pages 1 and 2 should be filed within 72 hours after death wil Department of Health and Mental Hygiene. Important: if item 27 is marked other than "natural", or items 23a only Injury or other traumatic event, the Medical Examirsa must be any Injury or other traumatic event, the Medical Examirsa must be applice. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 1 __Yes _ 2 No 14. Race - American Indian, 11. Marital Status Black White etc. 1 Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Black Specify: If Yes, Give Year or Dates: Specify: Completed by 3 Widowed 4 Divorced 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life, DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Manage a household Homemaker 18. Mother's Name (First, Middle, Maiden Surname 17. Father's Name (First, Middle, Last) Be 2 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Informant's Name/Relationship (Type. Print) Daughter 108 15th St N.E Whshington DC 500 L 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 1 Burial 2 ☐ Cremation 3 ☐ Removal from State 1-4-2010 Brentwood MD. incoln 4 ☐ Donation 5 ☐ Other (Specify) 814 Lipshur St NW 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Funeral Services Wdc 20011 Jellem 1182 Approximate Interval Between Onset and Death 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) **Physician** 11131 /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence) Examiner or Attending Physician: The law requires that the death certificate be executed Due to (or as a consequence of). Box 68760, Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Month Year in the past 12 months?
1 ☐ Yes 2 ☒ No 4 Pregnant at time of death 5 ☐ Other (specify) Division of Vital Records, P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 🎾 Unknown Be Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy 2 **X**No 2 No 1 □Yes 25. Was case referred to medical 26. Place of Death (Check only one) Other: 1 Yes 2 No 1 🗌 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) Medical Certification: To 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28d. Describe how injury occurred 1 Natural 5 Pending 1 ☐ Yes within 24 hours after deam.

To the Funeral Director: / 2 Accident investigation 6 Could not be determined 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide the Hospital 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier (Check only one) 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier -30-2009

Registrar
DHMH 17 Rev 1/2001

State

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

IN

8218W1360N

#305

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

Margaret Talbot		State of Maryland / Department of Healtr 1-For State Certificate of Death			2009	4255
Physici		Registrar 1. Decedent's Name (First, Middle,Last)		2. Date of Death		3. Time of Death
Medical Exami	ner	Margaret A. Talbott		Month December		1450 hrs
		4a. Facility Name (if not institution, give street and number) 4b. City, To 3415 Chestnut Avenue Baltime	own, or Location of Death ore		4c. County of Death	
Funeral		Social Security Number 6. Sex 7. Age (In yrs. last birthday) If Under		8. Date of Birth	(MM/DD/YYYY) 9. Birtl	hplace (State or
Director		218-52-2577 1 M 2 F 62 Yrs. Months	Days Hours Min.	Sept.	Foreigi 17. 1947 N	laryland
su s		Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location				10d. Inside City Limits
	ŗ	Maryland N/A Baltimore				1 Yes 2 No
Maryland 28a-f show d at once.	Director	10e. Street and Number 10f. Zip 0		100	g. Citizen of What Coun	try?
215-0036 be filed within 72 hours after death with the Maryland ntal Hygiene. rked other than "natural", or items 23a or 28a-f sho ont, the Medical Examiner, must be notified at once.	i Di		21211		USA	
eath w	Funeral	1 Never Married 2 Married Armed Forces? If Yes, specify	t of Hispanic Origin? (Spe Cuban, Mexican, Puerto R		14. Race - Americ White, etc.	can Indian, Black,
after d	by Fu		No specify:		_{Specif} White	
hours "natur Exam	ted t		occupation (Give kind of wo ing life. DO NOT use retire		16b. Kind of Business/Ir	
5-0036 led within 72 hours after Hygiene. other than "natural", the Medical Examiner.	Completed	12 Secreta	irv		Baltimore Police	-
21215-003 uld be filed withi Mental Hygiene. marked other tt		17. Father's Name (First, Middle, Last)	18.Mother's Name (I		aiden Surname)	
Z = 4 = 9	To Be	John Parsons 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address	(Street and Number or Ru	ra E. Pa		Zip Code)
MD 21215-0036 d 2 should be filed within 7 lth and Mental Hygiene. In 27 is marked other than numatic event, the Medical			cles Street 1		•	
s l an of Hea If iter		20a. Method of Disposition 1 Burial 2 XCremation 3 Removal from State 20b. Place of Disposition (Name crematory or other place)	,		20c. Location - City or 1	
Baltimore, permit. Pages I as Department of He Important: If ite injury or other tr		4 Donation 5 Other Specify: Atlantic Crema			Slen Burnie	
Balt permit. Depart Import injury		22. Name and A Burgee-	ddress of Facility -Henss-Seitz	Funeral	Home, Inc	. 21211
Physician		3631 Fa 23a. Part I. Erger the disease, or complications that caused the death. Do not enter the mode of failure. List only one cause on each line.	dying, such as cardiac or r	espiratory arres	st, shock, or heart	Approximate Interval Between Onset and
Examiner	H	Immediate Cause (Final disease a. Atherosclerotic Cardiovascular Disease				Death
		or condition resulting in death) Due to (or as a consequence of): Sequentially list conditions, b.				
	iner	if any, leading to immediate Due to (or as a consequence of):				
d sit	Examiner	(Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of):				
50, te be executed sysician and burial - transit	calE	dd				
Records, P.O. Box 68760, The law requires that the death certificate be executed cate has been signed by the attending physician and page 2 should be detached for use as the bunal - transi	Medical	IF FEMALE: 23c. If yes, outcome of pregnancy			23d. Date of delivery	
OX 6876 eath certificate eath certificate eath certificate for use as the	Physician/	23b. Was decedent pregnant in the past 12 months?	3 Ectopic pregnanc	су		ay Year
Box e death the atte	hysic	1 Yes 2 No 9 Unknown 9 Unknown 9 Unknown 9 Other (Specification of Unknown)	y)			
ires that the signed by I be detach	by P	Part II. Other significant conditions contributing to death but not resulting in the underlying c	ause given in Part I.		acco use contribute to the 2 No 3 Proba	
dS, Fequires	ted	Diabetes mellitus		24a. Was an		opsy findings available
e faw r e has b ge 2 sh	ompleted			autopsy	prior to co ned? death?	ompletion of cause of
ital Reco ician: The law s certificate has rector, page 2 s	ပ	25. Was case referred to medical 26	Place of Death (Check on	1 Yes 2	No 1 Yes	3 2 No
igh by Sign	To Be	examiner? 1 Yes 2 No Hospital: 1 Inpatient 2 ER/Outpatient 3 DO.			esidence 6 🗸 Other:	Scene
	Ë	(Month, Day Year)	c. Injury at Work? 26 1 Yes 2 No	8d. Describe ho	w injury occurred	
Division tal or Attendi s after death al Director: A	ertification	2 Accident Investigation 28e Place of Injury - At home, farm, street, factory, c		8f. Location (Str	eet and Number or Run	al Route Number, City
Divi	Cert	4 Homicide determined (Specify)		or Town, Sta	te)	
Divis To the Hospital or A within 24 hours after To the Funeral Dire completely filled in b		29a. Certifier (Check only 1 Certifying Physician: To the best of my knowledge, death occurred at the tire one) 2 Medical Examiner; On the basis of examination and/or investigation, in my o				
To t With To t	Medical	and manner stated.	License number		29d. Date signed (Mon	
			O.C.M.E.		December 31, 20	09
3√	}	30. Name and address of person who completed cause of death (Item 23a)				
	ata		treet, Baltimore, MD	21201		
St Regist	ate rar	31. Date filed (Month, Day, Year) 2010 32 Registrar's Signature Survey S				

OCME

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 2009 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ DECEMBER 37, 2009 12:05 PM TABOR MILDRED Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** 4c. County of Death FOREST HILL HEALTH & REHAB CENTER FOREST HILL HARFORD If Under 1 Year If Under 24 Hrs. 8. Date of Birth 5. Social Security Number 9. Birthplace (State or Foreign 6. Sex 7. Age (In yrs. last birthday) Funeral 1 M 2 F Days March 8, 1920 Indiana 89 278–12–4717 Director Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director must be notified Churchville Harford 1 Yes 2 No Maryland 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 21028 USA 205 Locust Hill Drive ural", or items ? 12. Was Decedent Ever in U.S. Armed Forces?

1 Yes 2 No
If Yes, Give Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Completed by 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify: Specify.White 3 Widowed 4 ☐ Divorced Year or Dates traumatic event, the Medical 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) d Mental Hygiene. marked other than Elementary/Seconday (0-12) College (1-4 or 5+) US Government Procurement Officer 12 Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) မ Addie Molton Aaron M. Stearns 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 205 Locust Hill Dr., Churchville, MD 21028 John Tabor - son Department of Health Important: If item 27 any injury or other th 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Date 1 M Burial 2 Cremation 3 Removal from State College Corner, Ohio 1/7/2010 College Corner Cem. 4 Donation 5 Other (Specify) 21. Signature Tarring-Cargo Funeral Home, P.A. 333 S. Parke St, Aberdeen, MD 21001 sanu 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Onset and Death Immediate Cause (Final Physician/ groboble preumonia disease or condition Medical resulting in death) Due to (or as a consequence of): Examiner de mantia 200 Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or linjury that initiated events Examine Due to (or as a consequence of): attending physician and for use as the burial-transil Due to (or as a consequence of): resulting in death) Last Physician/Medical P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death
4 Pregnant at time of death
9 Unknown 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy 5 Other (specify) in the past 12 months? Month Day Year Yes 2 No certificate has been signed by the rector, page 2 should be detached g Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by Division of Vital Records, RELEAT PULMONACH EMAN 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an DIODETTS autopsy 12 RE 1 Yes 2 No 25. Was case referred to medical Be 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 ☐ No မ 1 Inpatient 2 ER/Outpatient 3 DOA 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at Certificate: 28d. Describe how injury occurred 1 Natural
2 Accident
3 Suicide
4 Homicide work?
1 Yes 2 No injury 5 Pending Investigation Director; 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, determined City or Town, State) Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one) 29b. Signature and title of certifier 29c. License number 29d, Date signed (Month, Day, Year)

State Registrar Dans 5

DAVID DUNN

31. Date filed (Month, Day, Year)

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

615 W. MACPHAIL ROAD

32. Registrar's Signature

032532

BEL AIR, MD.

JAn

21014

2010

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death Reg. No edent's Name (First, Middle, Last) 2. Date of Death 230 **Physician** mes /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death City, Town, or Location of Death Examiner If Under 24 Hrs 01 6. Sex 7. Age yrs. last birthday) If Under 1 Year 9. Birthplace (State or Foreign 5. Social Security Number **Funeral** Date of Birth (Month, Day, Year) 1 □ M 2 □ F Months Days Hours Min. 417-66-4833 Director 95 15,1914 Alabama Usual Residence of Decedent the Maryland 10a. State 10b. County 10c. City. Town or Location ral", or items 23a or 28a-f show Examinate ust by notthed at 10d. Inside City Limits N/A 1√2 Yes 2 No Director Maryland Baltimore 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Pages 1 and 2 should be filed within 72 hours after death with nent of Health and Mental Hygiene. 717 Linnard Street 21229 USA Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 1 Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 1 ☐Yes 2 ☐ No Specify: Specify: Black þ 3 ☐ Widowed 4 ☐ Divorced "natural" Completed 7 is marked other than "natur traumatic event, the Medical 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Private Industry 7th grade Laborer 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be ဂ Unk. Dora Russo 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) of Health a Linnard Street Baltimore, Maryland 21229 Doris McGeachy/ Friend 717 item 2 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Date permit. Pages Department o Important: If i any injury or once. = 5 1 Burial 2 ☐ Cremation 3 ☐ Removal from State Zion Cemetery 12/31/09 Lansdowne, Maryland 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licenses 22. Name and Address of Facility Chatman-Harris Funeral Home own Rd Baltimore, MD 21215 5240 Reisterstown arri 23a. Part . Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease of Hjury that initiated events Due to (or as a consequence of): Examine Attending Physician: The law requires that the death certificate be execute attending physician and for use as the burial-tran resulting in death) Last Due to (or as a consequence of): P.O. Box 68760; Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Month 4 Pregnant at time of death Day Year 5 ☐ Other (specify) signed by the a d be detached for ☐Yes 2☐No 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part f. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, Completed by been si should t 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 X Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has page 2 s autopsy certificate 2 No 1 ☐Yes 2 ☐ No 1 Tyes After this certifications funeral director, p 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: Inpatient 2 ER/Outpatient 3 DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No Certification; To 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28h Time of 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural 2 Accident 5 Pending investigation To the Hospital or Attendit within 24 hours after death.

To the Funeral Director: A completely filled in by the fu death. 1 ☐ Yes 2 ☐ No 6 ☐ Could not be 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 ☐ Homicide 29a. Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

| Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) Medical (Check only one) and manner stated. 29b. Signature a 29d. Date signed (Month, Day, Year)

State Registrar 30. Name and address

31. Date filed (Month

on who completed cause of death (Item 23a) (Type, Print)

DHMH 17 Rev 1/2001 **OCME 2006**

State Registrar

111 Penn Street, Baltimore, MD 21201

Assistant Medical Examiner

32. Registrar's Signal

Melissa Brassell, MD

OCME

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. amend item 20b per fh 9900 2-8-10 vt. State of Maryland / Department of Health and Mental Hygiene 1 - State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Physician/ Ackerman June Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County, of Death Examiner Regional umberland Med 290 8. Date of Birth (Month, Day, Yea Jan 14 Birthplace (State or Foreign Country) **Funeral** Months 1 M 2 D F Hours ΤN 408-38-2223 81 Director Usual Residence of Decedent show 10c. City, Town or Location 10a. State 10b. County 10d. Inside City Limits er than "natural", or items 23a or 28a-f sho the Medical Examiner must be notified at Director WV Mineral Ridgeley 1 🗆 🗶es 2 🗆 No 10f. Zip Code 10e. Street and Number 10g. Citizen of What Country? Funeral 26753 USA 5 Lakewood Court Was Decedent of Hispanic Origin? (Specity Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 12. Was Decedent Ever in U.S 14. Race - American Indian, Armed Forces?

1 Yes 2 No
If Yes, Give Black, White, etc. 1 Never Married 2 Married \$ Maryland 21215-0036 hours after 1 ☐ Yes 2 ☐ 📉 Specify. Specify: Korea white 3 Widowed 4 Divorced Completed Year or Dates 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business Industry should be filed within 72 hand Mental Hygiene.
7 is marked other than "n Elementary/Seconday (0-12) College (1-4 or 5+) 12 own home homemaker Be 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) William S. Sutherland Lula Sutherland permit. Page 1 and 2 should be Department of Health and Mer Important: If item 27 is marke any injury or other traumatic e Injury or other traumatic 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code WV 26753 5 Lakewood Court Ridgeley Paul Ackerman son Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date cemetery, crematory or other place) St. Mary's Cemetery 1 XBurial 2 Cremation 3 Removal from State 1-4-10⁻⁴² MD Cumberland 4 Donation 5 Other (Specify) 21. Signature of Funer ice Liqensee 22. Name and Address of Farility eral Home, PA 108 Virginia Avenue: Cumberland, MD 21502 23a. Part. Enter the disease, or complications that caused the death. Do not enter the mode of dyin shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ nivat disease or condition Medical resulting in death) Examiner Sequentially list conditions, onsequence of): Examine if any, leading to immediate sician and burial-transit Cause (Disease or iinjury that initiated events Due to (or resulting in death) Last as a consequence of): attending physician for use as the buria Physician/Medical The law requires that the death certificate be Box 68760 IF FEMALE 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy
5 ☐ Other (specify) ____ in the past 12 months? Year Month Day Pregnant at time of death signed by the a g Unknown P.O. I Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by Division of Vital Records, 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown cate has been sig page 2 should b 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? certificate Yes 2 No 2 🗌 No To the Hospital or Attending Physician: within 24 hours after death.

To the Funeral Director: After this certifica completed filled in by the funeral director, to 26. Place of Death (Check only one) 25. Was case referred to medical Be examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2-No ည 1 Annpatient 2 ER/Outpatient 3 DOA 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred Certificate: Natural 5 Pending 1 ☐ Yes 2 ☐ No М Accident
Suicide Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) ☐ Homicide Medical Lactifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated 29a. Certifie Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certifier 29c. License numbe 29d. Date signed (Month, Day, Year) 2010 who completed cause of death (Item 23a) (Type, Print) rne and address Demorial Avenue Cumberland, MO 21502 32. Registrar's S State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

		•	1 - State of Maryland / Dep	partment of Health and ertificate of Death		iene eg. No. 2009 42562
	Discolate a		Decedent's Name (First, Middle, Last)		2. Date of Deat	h 3. Time of Death
	Physicia Medic		Ronald E. Alvaro			ber 22 2009 2125M
	Examin	er	4a. Facility Name (if not institution, give street and number)	4b. City, Town, or Location of Deat		4c. County of Death
	Funeral		5. Social Security Number 6. Sex 7. Age (In yrs. last birthday)	If Under 1 Year I if Under 24 Hrs	8. Date of Birth	Allegany 9. Birthplace (State or Foreign
	Director		234-62-4113 1 [™] M 2 □ F 72 Yrs.	Months Days Hours Min.	(Month, Day, May 7	Year) 1937 Keyser, WV
	d ow t	_	Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or L			
	arylan a-f sh fied a	Director	l sou ord, round of			10d. Inside City Limits 1 ☐ Yes 2 ☒ No
	or 28		WV Mineral Key:	10f. Zip Code	1	log, Citizen of What Country?
	with 1 s 23a ust b	Funeral	Rt. 4, Box 198-C Stony Run Road	26726		USA
	death items ier m	Fun		Was Decedent of Hispanic Origin? (S If Yes, specify Cuban, Mexican, Puert	pecify Yes or No-	14. Race - American Indian,
36	within 72 hours after death with the Maryland giene. er than "natural", or items 23a or 28a-f sho the Medical Examiner must be notified at	d by	1 Never Married 2 Married 1 Yes 2 No	1 ☐ Yes 2 🛣 No Specify:	o (trous, otol)	Black, White, etc.
21215-0036	nours latura ical E	Completed	leal of Dates.	edent's Usual Occupation		White 16b. Kind of Business Industry
215	in 72 l e. ian "r Med	dmo	(Specify only highest grade completed) (Give	e kind of work done during most of wor DO NOT use retired)	rking	Tob. Kind of Business muustry
2	ygien ygien her th	l o	5+ Te	eacher		Secondary Education
and	e filed ntal Hy ed oth event:	To B	17. Father's Name (First, Middle, Last) James E. Alvaro		me (First, Middle, N	,
Maryland	should be fil n and Mental 7 is marked or raumatic eve			ling Address (Street and Number or Ru	E. Broad	
	0 ± 5 ±				Keyser,	
ore,	of Heal of Heal if item 2		20a. Method of Disposition 20b. Place of Disp	osition (Name of	Date	20c. Location - City or Town, State
ij	Page ment tant: I		4 Donation 5 Other (Specify) Potomac N	lemorial Gardens	Dec. 28	Keyser, WV
Baltimore,	permit. Page 1 Department of Important: If i any injury or once.	. 15 5 15		22. Name and Address of Facility Sm		
	222 6 0		23a. Part 1. Enter the disease, or complications that caused the death. Do not en	35 S. Main Street	Keyser	
ı	Hysician		shock, or heart failure. List only one cause on each line.			st, Approximate Interval Between Onset and Death
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Spanner	Examiner	L	Sequentially list conditions, b.			
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36	and I-trans	Examine	Cause (Disease or linjury that initiated events c			
09	res that the death certificate be executed signed by the attending physician and if be detached for use as the burial-transit	dical	d			
876	ificate ng phy as the	Med	IF FEMALE:			
Box 687	th cert tendir or use	ian/	23b. Was decedent pregnant 23c. If yes, outcome of pregnancy 1 \subseteq Live Birth 2 \subseteq Fetal death 3	Ectopic pregnancy		23d. Date of delivery
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P.O.	hat thed by		Part II. Other significant conditions contributing to death but not resulting in the	underlying cause given in Part I.	23e. Did tob	acco use contribute to the cause of death?
JS, I	uires l in sign uld be	ed by			1 □ Ye	es 2 No 3 Probably 4 Unknown
Sorc	av require as been si 2 should l	plet			24a. Was an	
Rec	ysician: The law is certificate has director, page 2 :	Completed			perform	
ita	ician: The certificate rector, pag	Be	25. Was case referred to medical examiner?	26. Place of Death (Che	ck only one)	
)f \	Phys r this aral dir	<u>ان</u>	27. Manner of Death 28a. Date of injury 28b. Time of	ent 3 🗆 DOA 📗 4 🗀 Nursing F	lome 5 Reside	nce 6 Other (Specify)
nc	death. stor: Afte the fune	icat	1 Natural 5 Pending (Month, Day, Year) injury 2 Accident Investigation	work? M 1 Yes 2 No	20d. Describe not	w injury occurred
Division of Vital Records,	r Atte ter de irecto	Certificate:	3 ☐ Suicide 6 ☐ Could not be 4 ☐ Homicide determined 28e. Place of Injury - At home, farm, si building, etc. (Specify)	reet, factory, office	28f. Location (Str. City or Town,	eet and Number or Rural Route Number,
Ö	oital o iurs af eral Di					
	To the Hospital or Attending Physician: The law requires that the death certifica within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physompleted filled in by the funeral director, page 2 should be detached for use as the completed filled in by the funeral director, page 2 should be detached for use as the completed filled in by the funeral director, page 2 should be detached for use as the completed filled in by the funeral director, page 2 should be detached for use as the completed filled in by the funeral director, page 2 should be detached for use as the completed filled in by the funeral director, page 2 should be detached for use as the completed filled in by the funeral director.	Medical	29a. Certifier (Check (Check only one) 3 Certifying Physician: To the best of my knowledge, death	stigation, in my opinion, death occurred :	at the time, date and	place, and due to the cause(s) and manner stated.
	To the comp	2	29b. Signature and title of certifier	29c. License number	25	2d Date signed (Month Day Year)
			Swan & South Mo	D0018216		12/23/2009
_	7		30. Name and address of person who completed cause of death (Item 23a) (Type, Stoven R Smith M 1250	DI Willowbrook R	ed Cun	12/23/2009 nberland MD 21502
	Stat Registra	e ir	31. Date filed (Month, Day, Year) 32. Registrary Signature			

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Month DECEMBER 2009 9:06 \mathbb{E} ANDRUKITE Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** 4c. County of Death FREDERICK HOSPITAL FREDERICK FREDERICK MEMORIAL If Under 1 Year If Under 24 Hrs. Months Days Hours Min. Social Security Number 7. Age (In vrs. last birthday 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** 1 **X** M 2 □ F Months Feb 24, 1924 Pennsylvania Director 85 193-16-7587 Usual Residence of Decedent 28a-f shov 10b. County Page 1 and 2 should be filed within 72 hours after death with the Maryland trneft of Health and Mental Hyglene. That If item 27 is marked other than "natural", or items 23a or 28a-f sho iury or other traunatic event, the Medical Examiner must be notified at iury or other traunatic event, the Medical Examiner must be notified at 10c. City, Town or Location 10d. Inside City Limits Director 1 X Yes 2 No MD Frederick Frederick 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 2402 Ellsworth Way #1C 21702 USA Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 12. Was Decedent Ever in U.S. 14 Race - American Indian. Armed Forces?

1 X Yes 2 No
If Yes, Give Black, White, etc. Completed by 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☐XNo Specify. Specify: 3 Divorced White Year or Dates. 1943-46 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b, Kind of Business Industry (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) Carpenter Federal Government Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ပ John Edward Andrukite Lena Urbanski 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 2402 Ellsworth Way #1C Frederick, MD 21702 Freida Andrukite/wife 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State permit. Page 1
Department of
Important: If it
any injury or o 1 Burial 2 X Cremation 3 Removal from State Final Journey Crematory 12/16/09 Woodbine, MD 4 ☐ Donation 5 ☐ Other (Specify) 21. Signat of Funeral Service Licenses Going Home Cremation Service P.O. Box 784 Beverly L. Heckrotte, P.A. CLarksville, MD 21029 23a. Part 1. Enter the deease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between shock, or heart failure. List only one cause on each line Immediate Cause (Final disease or condition resulting in death) Onset and Death Priysician/ neumania Medical Due to (or as a consequence of): Examiner Sequentially list conditions, in any, leading to incrediate cause. Enter Underlying Examiner Due to (or as a consequence of) transit. Cause (Disease or linjury that initiated events resulting in death) Last and Due to (or as a consequence of): ending physician a use as the burial-1 Physician/Medical the Hospital or Attending Physician: The law requires that the death certificate be Division of Vital Records, P.O. Box 68760 been signed by the attending I should be detached for use as IF FEMALE: yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant Live Birth 2 Fetal death 3 Ectopic pregnancy in the past 12 months?
1 ☐ Yes 2 ☐ No Month Pregnant at time of death Year 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Completed by 2 No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available 24a. Was an After this certificate has funeral director, page 2 prior to completion of cause of death? autopsy 2 🗆 No 1 Yes the funeral director, Be (25. Was case referred to medical 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 No ည 1 Inpatient 2 ER/Outpatient 3 DOA 27. Manner Ceath 28a. Date of injury 28b. Time of Certificate: 28c. Injury at work? 28d. Describe how injury occurred 1 V Natural (Month, Day, Year) injury 5 Pending 1 Yes 2 No Accident Investigation 24 hours after death Funeral Director: 3 Suicide
4 Homicide 6 ☐ Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) within 24 hours after de To the Funeral Directo completed filled in by the 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Medical Ecrtifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a, Certifie (Check Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 3 🗍 only one) 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year)

State Registrar D60417

Tohnson Dr.

Frederick MD 21702

MD

32. Registrar's Signature

MANA

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene State
Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death DECEMBER Day 16 2009 Physician/ 10:05P M ABOT SERVANDA Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner PRINCE GEORGE'S LANHAM 9114 91st PLACE If Under 1 Year If Under 24 Hrs. 9. Birthplace (State or Foreign 8. Date of Birth Social Security Number 6. Sex Age (In yrs. last birthday) **Funeral** Days Hours OCT 26 1 - M 2 XF PHILLIPINES 1926 Director 83 Yrs. 576-08-6843 Usual Residence of Decedent "natural", or items 23a or 28a-f show edical Examiner must be notified at 10d. Inside City Limits 10a. State 10b. County 10c. City, Town or Location within 72 hours after death with the Maryland Director 1√2 Yes 2 □ No PRINCE GEORGE'S HYATTSVILLE MD 10e. Street and Number 10f, Zip Code 10g. Citizen of What Country? Funeral USA 20784 7109 MARYWOOD STREET Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☒ No 14, Race - American Indian, 11. Marital Status Black, White, etc þ 1 Never Married 2 Married Maryland 21215-0036 Specify: PHILLIPINES 1 X Yes 2 □ No Specify: ASIAN If Yes, Give Year or Dates. 3 ▼Widowed 4 □ Divorced Completed Medical 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry permit. Page 1 and 2 should be filed within 72 h Department of Health and Mental Hygiene. Important: If item 27 is marked other than "ne any injury or other traumatic event, the Medic once. (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) PRIVATE FARMER 6th Be 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) ပ NADONGA JULIANA CALIXTRO NAING 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 5321 TAYLOR ROAD RIVERDALE, MARYLAND 20737 ESTEBAN NAING ABOT/SON Baltimore, 20a. Method of Disposition 20c. Location - City or Town, State 20b. Place of Disposition (Name of Date 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) cemetery, crematory or other place) GEORGE WASHINGTON CEME 12/23/2009 ADELPH3 , MARYLAND J. B. JENKINS FUNERAL HOME 21. Signature of Juneral Service Licensee 7474 LANDOVER ROAD LANDOVER, MARYLAND 20785 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Interval Between Onset and Death Immediate Cause (Final Physician/ disease or condition Medical resulting in death) **Examiner** Sequentially list conditions, Examine if any, leading to immediate cause. Enter Underlying Cause (Disease or linjury ng physician and as the burial-transit The law requires that the death cer ificate be executed that initiated events resulting in death) Last Physician/Medical Box 68760 IF FEMALE: ttending for use a ves, outcome of pregnancy
Live Birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3

Ectopic pregnancy in the past 12 months? Dav 5 Other (specify) Pregnant at time of death 9 Unknown P.O. þ Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. signed t 23e. Did tobacco use contribute to the cause of death? by 1 Yes 2 No 3 Probably 4 Unknown Records, cate has been sig page 2 should b Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? Yes 2 X No 1 ☐ Yes 2X No this certificate Division of Vital the Hospital or Attending Physician: 25. Was case referred to medical 26. Place of Death (Check only one) Be examiner? Other: 4 \square Nursing Home 5 \square Residence 6 \square XOther (Specify) HOSPICE 2 LyNo 1 Inpatient 2 ER/Outpatient 3 DOA မ : After this funeral of 28b. Time of 27. Manner of Death 28a. Date of injury 28c. Injury at 28d. Describe how injury occurred Certificate: work? 1 ☐ Yes 2 ☐ No (Month, Day, Year) injury 1 X Natural 5 Pending To the Hospital or Attendin within 24 hours after death.

To the Funeral Director; Aff completed filled in by the fur М Investigation 6 Could not be Accident 3 ☐ Suicide 4 ☐ Homicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, determined City or Town, State) Medical 1 X Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated (Check Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 3 🗆 29b. Signature and title of certif 29d. Qate signed (Month, Day, Year) 300° 006 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 7525 GREENWAY CENTER DRIVE SUITE 313 GREENBELT, MARYLAND 20770 KHALID ASHAI M.D.

State

31. Date filed (Month, Day, Year)

DEC 2 2 2009

32 Registras's Signature Jan

Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Registrar 1. Decedent's Name (First, Middle, Last) 2. Date of Death December Physician/ 2009 Allen 9:19 p M Bessie Marie Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Prince Georges Clinton Southern Maryland Hospital 9. Birthplace (State or Foreign If Under 1 Year If Under 24 Hrs. 8. Date of Birth Social Security Number 7. Age (In vrs. last birthday) Funeral 1 □ M 2 🏝 F Days Hours March 12, 1939 Franklin Cty, N.C. 70 Director 245-62-6735 Usual Residence of Decedent permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If then 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must he patterned once. 10c. City, Town or Location 10d. Inside City Limits 10a. State 10b. County Director Maryland Prince Georges Suitland 1 🖾 Yes 2 🗆 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral United States 20746 3336 Curtis Dr. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 Never Married 2 X Married þ 1 ☐ Yes If Yes, Give 2X No Baltimore, Maryland 21215-0036 **Black** 1 Yes 2 No Specify: 3 Widowed 4 Divorced Completed Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation 16h Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) Private Food Technician Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ည Mary Elizabeth Solomon Thomas Maurice Foster 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 3336 Curtis DR. Suitland, Md. Johnnie M. Allen / Spouse 20a. Method of Disposition
1 → Burial 2 □ Cremation 3 □ Removal from State 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Maryland Veterans 12/29/2009 Cheltenham, Md. 4 Donation 5 Other (Specify) Name and Address of Facility Alexander S. Pope, /P 5538 Marlboro Pike/ Signature of Funeral Service L Forestville, MD. 20747 Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Priysician/ disease or condition Medical resulting in death) **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury that initiated events Examine To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completed filled in by the funeral director, page 2 should be detached for use as the burial-transit resulting in death) Last Physician/Medical Box 68760 IE EEMALE 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregna 5 ☐ Other (specify) Ectopic pregnancy in the past 12 months? Month Day Year Pregnant at time of death Unknown 9 Unknown Division of Vital Records, P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a Was an autopsy performed? Yes 2 No 1 ☐ Yes 2 ☐ No 25. Was case referred to medical 26. Place of Death (Check only one) Be examiner? Hospital 2 No 1 \square Yes 1 Inpatient 2 KER/Outpatient 3 IDOA မြ 4 Nursing Home 5 Residence 6 Other (Specify) . Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred Certificate: 1 Natural work 5 Pending 1 ☐ Yes 2 ☐ No 2 Accident
3 Suicide Investigation 6 Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide determined Medical 1 🗶 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
3 Certifying the Practioner: To the best of my nowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one 29b. Signature and title o 29d. Date signed (Month, Day, Year)

State

Registrar

person who completed cause of death (Item 23a) (Type, Print)

Physician	
/Medical	
Examiner	

Funeral Director

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, it is Medical Examinar must be notified at once.

Physician /Medical Examiner

Baltimore, Maryland 21215-0036

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death,

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Division of Vital Records, P.O. Box 68760.

To the Ho within 24.1

	1 - For State Registrar	State of Maryla		rtificate of			Reg. No.	9	42566			
an	1. Decedent's Name (First, Middle, Last) 2. Date of Death Month Day Year DECEMBER 15 2009											
cal	RENEE 4a. Facility Name (If not institution, give	009	2:53 A M									
ier	PRINCE GEORGE'S	· ·		4b. City, Town, o			4c. County of Death PRINCE GEORGE 'S					
	Social Security Number 6. Sec.	7. Age (In yi	7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth					place (State or Foreign				
	210 27 0330]м 27Д г 29	Yrs.	Months Days	Hours Min.	AUG 26			INGTON, DC			
	Jsual Residence of Decedent Oa. State 10b. County 10c. City, Town or Location								0d. Inside City Limits			
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irec	10e. Street and Number	Vhat Cour	ntry?									
a D	1 HABERSHAM COURT 20906 USA											
ner	11. Marital Status	12. Was Decedent Ever in Armed Forces?	U.S. 13. \	Was Decedent of H f Yes, specify Cuba	lispanic Origin? (S	pecify Yes or No- o Rican, etc.)	14. Raci	e - Americ k, White,	can Indian,			
Completed by Funeral Director	1 ☐ Never Married 2 ☐ Married 3 ☐ Widowed 4 ☐ Divorced	1 ☐ Yes 2 ☐ No If Yes, Give Year or Dates:		I∐Yes 2∏XNo	Specify:		Specify	73.7	ACK			
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ple	(Specify only highest grad	completed) College (1-4or 5+)	(Give life. L	kind of work dane o DO NOT use retired	during most of wor i)				,			
Son	Elementary/Secondary (0-12)		DAY	CARE ASS	ST. TEACH	ER	PRIVAT	E	-			
To Be	17. Father's Name (First, Middle, Last) ALEXANDER ANIM					ne <i>(First, Middle,</i> MENSAH—F		e)				
-	19a. Informant's Name/Relationship (Ty	pe. Print)		ng Address (Street								
	ALEX D. ANIM/BRO			ARK VISTA		ILVER SE	PRING, MA	RYLA	ND 20906			
	20a. Method of Disposition 1 ☑ Burial 2 ☐ Cremation 3 ☐ P			sition (Name of natory or other plac		Date	20c. Location -	•				
	4 Donation CEME. 12/21/2009 SILVER SPRING, MARYLAND											
	21 Signature of Fineral Service Licensee 22. Name and Address of Facility J. B. JENKINS FUNERAL HOME 7474 LANDOVER ROAD LANDOVER, MARYLAND 20785											
	23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death											
	Immediate Cause (Final disease or condition resulting in death) CARDIOMYOPATHY											
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	IF FEMALE:	3c. If yes, outcome of preg	nancy				001 0					
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ပ္ပ		med?	death? I∐Yes									
æ	25. Was case referred to medical examiner?	ospital: V		t 3 DOA Oth	or:	th (Check only or		ie)				
5	1 ☐ Yes 2 📉 No 27. Manner of Death	ospital: 14 Inpatient 2	☐ ER/Outpatien 28b. Time of	t 3 ☐ DOA ☐ Our 28c. Injur	T L Nuising 13	ome 5 Resid			(y)			
tion	1 X Natural 5 ☐ Pending 2 ☐ Accident investigation	(Month, Day, Year)	Injury	Work	Yes 2 □No	Zou. Describe ii	ow injury occur.	e u				
ifica	3 Suicide 6 Could not be determined	28e. Place of Injury - At	home, farm, stre			28f. Location (S	treet and Numb	er or Rura	al Route Number,			
Cert	4 Hollicide	building, etc. (Spe				City or Tow						
Medical Certification: To	29a. Certifier 1 Certifying Phys (Check only one)	sician: To the best of my k	nowledge, death	occurred at the tir vestigation, in my o	ne, date and place pinion, death occu	e, and due to the our	cause(s) and ma	anner as s and due to	stated. the cause(s)			
Mec	29b. Signature and title of certifier	and manner stated.		29c. Licens	e number	- 2	29d. Date signed	i (Month,	Day, Year)			
	1 Let m	1 Pin	$\overline{\mathbf{O}}$	DOO	2602/		DECEMB					
}	30. Name and address of person who co	mpleted cause of death (It	em 23a) (Type, f		26024		DECEID	LIX 1/	, 2007			
	LESTER MILES M.D.	1160 VARMUN	STREET		HINGTON,	DC 2001	7					
te	31. Date filed (Month, Day, Year)	32. Registrar's Si g	Soul !	•								

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Medical Month 2/26/2009 III Boykin William 2:55 am^M 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Prince George Examiner Clinton Southern Md Hospital 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** 1**XX**M 2 □ F Days Hours 6/09/1933 76 **Director** 249-40-6990 South Carolina Usual Residence of Decedent ral", or items 23a or 28a-f show Examiner must be notified at 10a. State 10b. County 10c. City, Town or Location Forestville 10d. Inside City Limits filed within 72 hours after death with the Maryland irector Prince George Md 1 Yes 2X XNo ۵ 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 20747 Funeral 8217 Steve Dr 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. "natural", or ò 1 Never Married 2 Married 1 √Yes 2 □ No If Yes, Give 1954 Year or Dates. Specify: Black Maryland 21215-0036 1 Yes 2XXNo Specify Completed 3 Widowed 4 Divorced permit. Page 1 and 2 should be filed within 72 hour Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natur any injury or other traumatic event, the Medical any injury or other traumatic 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) College (1-4 or 5+) Elementary/Seconday (0-12) Gov't. Manager 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Hager Jackson William Boykin 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 8217 Steve Dr Forestville Md 20747 Mattie Boykin(Wife) Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of Date 20c. Location - City or Town, State 1 LxBurial 2 Cremation 3 Removal from State National Cemetery Columbia S.C. Jan 4,2010 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of FacilitRoger J Mason Funeral Service 21. Signature o Funeral Service 5801 Cleveland Áve Riverdale Md 20737 23a. Part 1. En shock, of ase, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest e. List only one cause on each line. Immediate dause (Findisease or condition Onset and Death Physician/ Medical resulting in death) Due to (or as a con equence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury that initiated events Due to (or as a consequence of) Exami attending physician and for use as the burial-transit resulting in death) Last Physician/Medical Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ____ in the past 12 months?
1 ☐ Yes 2 ☐ No Pregnant at time of death been signed by the should be detached Unknown 9 Unknown P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by Vascular Accident, Aspiration Preumonia 1 Yes 2 No 3 Probably 4 Unknown Records, 24b. Were autopsy findings available prior to completion of cause of death? Thrombosis 24a Was an Vein To the Hospital or Attending Physician: The law this certificate has all director, page 2 performed' 1 Yes 2 No Yes 2 No r After this certifica Division of Vital 25. Was case referred to medical 26. Place of Death (Check only one) Be examiner? 1 🗌 Yes 2 No Other: မြ 1 Inpatient 2 ER/Outpatient 3 I DOA 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 27, Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 1 Natural Certificate: 28c. Injury at 28d. Describe how injury occurred 5 Pending work' within 24 hours after death.

To the Funeral Director. Af
completed filled in by the fu 2 🗌 No Accident Investigation 3 Suicide
4 Homicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Me in a Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated (Check Confitting Nurse Practioner: To the best of my knowledge, death booked at the time, date and place, and due to the and title of contifier 29b. Signature who completed cause of death (Item 23a) (Type, Print)

State Registrar

MAN 0 7 2010

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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 2009 for State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Roscoe Conklin Bussard Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Washington Washington County Hospita1 Hagerstown If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) June 19, 1 Social Security Number 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign **Funeral** 1 X M 2 🗆 F Months Days Hours Min. Country)
Maryland Director 85 217**-**09**-**9858 Usual Residence of Decedent or 28a-f shov notified at 10a. State 10b, County 10d. Inside City Limits 10c. City, Town or Location Director 1 Yes 2 ☐ No Maryland Washington Hagerstown 10f. Zip Code 10g. Citizen of What Country? ö 10e. Street and Number "natural", or items 23a or edical Examiner must be Funeral with S. Cleveland Ave. 21740 U.S.A. . Page 1 and 2 should be filed within 72 hours after death virent of Health and Mental Hygiene.
start If item 27 is marked other than "natural", or items luny or other traumatic event, the Medical Examiner muliury or other traumatic event, the Medical Examiner mulius or other traumatic event, 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-11. Marital Status 14. Race - American Indian Armed Forces?

1 Yes 2 No lf res, Give Yes, specify Cuban, Mexican, Puerto Rican, etc.) Black, White, etc 1 Never Married 2 Married ģ Baltimore, Maryland 21215-0036 1 Tes 2 No Specify: Specify: 3 Widowed 4 Divorced Completed White Year or Dates 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business Industry Elementary/Seconday (0-12) College (1-4 or 5+) 10 Poster Hanger Advertising Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ည C. Bussard Jennie Brown Roscoe 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Eugenia M. Bussard / Wife Cleveland Ave. Hagerstown Maryland 21740 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State permit. Page 1 a
Department of H
Important: If ite
any injury or ott 1 Burial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify) Rest Haven Cemetery 12/28/2009 Hagerstown, Marvland 21. Si vat le of Funer S V e Licen 22. Name and Address of Facility Rest Haven Funeral Chapel 1601 Pennsylvania Ave Hagerstown Maryland 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ PROBABLE ACUTE MYDCARDIAL INFARCTION disease or condition resulting in death) MUKAINON Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Examine Due to (or as a consequence of) for use as the burial-transi that initiated events resulting in death) Last Due to (or as a consequence of): attending physician Completed by Physician/Medical Hospital or Attending Physician: The law requires that the death certificate be P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy
5 Other (specify) in the past 12 months?
1 ☐ Yes 2 ☐ No Pregnant at time of death ed by the a detached f 9 Unknown g Unknown signed by: Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? HEART FAILURE Division of Vital Records, congestive 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☑ Unknown page 2 should certificate has been 24b. Were autopsy findings available prior to completion of cause of death? SYNDROME 24a. Was an autopsy 1 ☐ Yes 2 X No 25. Was case referred to medical examiner? completed filled in by the funeral director, 26. Place of Death (Check only one) Be Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 No Hospital: မ 1 Inpatient 2 KER/Outpatient 3 IDOA After this 28c. Injury at work?
1 Yes 2 No 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28d. Describe how injury occurred Certificate: iniury 1 📈 Natural 5 Pending within 24 hours after death To the Funeral Director: A 2 Accident Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined City or Town, State) Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check the 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) 0058181 DECEMBER 24 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 9+1

State Registrar 32. Registrar's Sign

324 E. ANTIETAM ST # 306 HAGTERSTOWN

21740

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death

DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) ^{Day}18, 2009 Physician/ 4:50 Рм December Bogler Margaret Medical 4c. County of Death 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death Examiner Calvert Chesapeake Beach 3551 Karen Drive If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign Social Security Number 7. Age (In yrs. last birthday) Funeral Min 05-06-1913 HUMBary 1 🗆 M 2 👿 F Yrs 96 Director 500-30-2042 Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location or 28a-f shov 10b. County 10a. State permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f sho any injury or other traumatic event, the Medical Examiner must be notified at. Funeral Director 1 ☐ Yes 2X No Chesapeake Beach MD Calvert 10f. Zip Code 10g. Citizen of What Country? 10e Street and Numbe USA 20732 3551 Karen Drive 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14 Race - American Indian. 12. Was Decedent Ever in U.S. 11. Marital Status Armed Force Black White, etc. ☐ Yes 2 🗓 No 1 Never Married 2 Married Completed by Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify Specify: White If Yes, Give 3 Widowed 4 □ Divorced Year or Dates 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) Manufacturing Bookkeeper Be 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First. Middle, Last) ပ Hermione Schwartz David Rottenberg 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 3551 Karen Drive Chesapeake Beach, MD 20732 Ruth Rondberg / Daughter 20b. Place of Disposition (Name of cemetery, crematory or other place, 20c. Location - City or Town, State 20a. Method of Disposition 1X Burial 2 Cremation 3 Removal from State National Memorial Park 12-23-2009 Falls Church, VA 4 Donation 5 Other (Specify) Found & Sons Lee Funeral Chapel 22. Name and Address of Facility Signature of Funeral Service Lic 8521 Sudley Road, Manassas, VA 20109 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ DAGEST disease or condition Medical resulting in death) Due to (or as a consequence of): Examiner Sequentially list conditions, Examiner Due to (or as a consequence of) if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury that initiated events To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director After this certificate has been signed by the attending the funeral director news of the funeral d Due to (or as a consequence of) resulting in death) Last Physician/Medical IE EEMALE 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Day in the past 12 months? Month Year 5 Other (specify) Pregnant at time of death 2 No 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. by 2-No 3 Probably 4 Unknown 1 🗌 Yes Completed 24b. Were autopsy findings available prior to completion of cause of 24a. Was an autopsy performed? death? 1 ☐ Yes 2 ☐ No Yes 2 No 26. Place of Death (Check only one) Be 25. Was case referred to medica 4 Nursing Home 5 Residence 6 T Other (Specify) daughter's 2 X No 1 Inpatient 2 ER/Outpatient 3 DOA 1 Tes ᅆ 28a. Date of injury (Month, Day, Year) 28d. Describe how injury occurred 27 Manner of Death 28b. Time of 28c. Injury at residence Certificate: injury work?
1 Yes 2 No 1 Natural 5 Pending Accident Suicide Investigation 6 Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide determined Medical Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Defining Physician. To the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

| Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
| Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check 29d. Date signed (Month, 29c. License numbe 29b. Signature and title of certifier

Registrar
DHMH 17 Rev 7/2009

State

10845 Town Center Blvd., Suite 204, Dunkirk, MD 20754

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Jonathan Lowenthal,

JAN 0 7 2010

31. Date filed (Month, Day, Year)

M.D.,

32, Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Olive Gayle Bowman Month Day AM ecembe Medical 4c. County of Death 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death Examiner Washington County Hospital Hagerstown Washington 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign Funeral (Month, Day, Year) April 23,1920 Months Days Hours Min. 215-18-2202 89 Director Maryland April Usual Residence of Decedent 28a-f shov 10b. County 10c. City, Town or Location aţ 10a. State 10d. Inside City Limits within 72 hours after death with the Maryland Director Examiner must be notified 1 Yes 2 No Maryland Washington Smithsburg 10e. Street and Number 10f. Zip Code P 10g. Citizen of What Country? 23a Funeral 12103 Pleasant Valley Road 21783 USA , or items 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14. Race - American Indian Black, White, etc. 3 1 Never Married 2 Married 1 ☐ Yes 2X No Baltimore, Maryland 21215-0036 1 ☐ Yes 2X No Specify: If Yes, Give Year or Dates Specify: "natural", 3 ☑ Widowed 4 ☐ Divorced Completed White the Medical 15. Decedent's Education 16a. Decedent's Usual Occupation 16b Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working permit. Page 1 and 2 should be filed within 7. Department of Health and Mental Hygiene. Important: If item 27 is marked other than any injury or other traumation. life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) Fruit Grader Orchard Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) မ Clyde Allen Buhrman Leacy Rea Toms 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) *Maxine Bowman* (Daughter) 12103 Pleasant Valley Rd. Smithsburg, Maryland 21783 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date cemetery, crematory or other place) 1 X Burial 2 Cremation 3 Removal from State Dec. 2 2009 Smithsburg, Maryland Pleasnt Valley Cemetery 4 Donation 5 Other (Specify) 21. Signature of Funeral Service Licenses 22. Name and Address of Facility J.L. Davis Funeral Home 12525 Bradbury Ave. Smithsburg, Maryland 21783 art 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause an each line Interval Between Onset and Death Immediate Cause (Final d flysician/ Na disease or condition resulting in death) Medical Due to (o as a consequence of): Examiner Sequentially list conditions Examine if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Due to (or as a consequence of) attending physician and I for use as the burial-transit Hospital or Attending Physician: The law requires that the death certificate be executed that initiated events consequence of): resulting in death) Last Physician/Medical Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy
 5 Other (specify) _____ in the past 12 months? Pregnant at time of death the Unknown g Unknown s been signed by the should be detached Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 Yes 2 No 3 Probably 4 Onknown Completed 24b. Were autopsy findings available prior to completion of cause of 24a. Was an certificate has autopsy page death? Yes 2 No 1 Yes 2 No After this certifical funeral director, I 25. Was case referred to medical **Division of Vital** Be 26. Place of Death (Check only one) examiner? Hospital Other: 1 🗌 Yes 2 400 1 Inpatient 2 ER/Outpatient 3 IDOA ပ 4 Nursing Home 5 Residence 6 Other (Specify) 28a. Date of injury (Month, Day, Year) 27. Manner_of Death 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred 1 Natural injury 5 Pending after death.

Director: Aft
in by the fur 1 Yes 2 No M Accident Investigation Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 28f. Location (Street and Number or Rural Route Number determined filled in I within 24 hours a

To the Funeral D

completed filled i ledical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 3 only one) 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year, 29c. License number

Registrar
DHMH 17 Rev 7/2009

State

1 11

Name and address of person who completed cause of death (Item 23a) (Type, Print)

32. Registra

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.
AMEND TTEM#20b, perFH, G899, 1/7/2010, WS
State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death Reg. No-3. Time of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Dav Year **Physician** Ivan Granville Briscoe December 21,2009 11:45 A /Medical 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) Examiner Calvert Memorial Hospital Prince Frederick Calvert s. Pate of Birth September 2,1921 Country) If Under 1 Year | If Under 24 Hrs. yrs. last birthday) 5. Social Security Number **Funeral** Days Hours 88 **X** M 2 □ F 234-28-4674 West Virginia Director Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 10a State 10b. County 28a-f show r than "natural", or items 23a or 28a-f shov the Medical Examiner must be notified at 1 ☐Yes 2 No Charles Waldorf Maryland Director 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number 20603 United States 3121 Floating Leaf Lane death Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☑ Yes 2 ☐ No If Yes, Give Year or Dates: 14. Race - American Indian, Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Black, White, etc. 1 Never Married 2 Married Specify: White 1 ☐ Yes 2 🛣 No altimore, Maryland 21215-0036 þ 3 X Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) filed within 72 Department of Navy Elementary/Secondary (0-12) College (1-4or 5+) Machinist Helper permit. Pages 1 and 2 should be filled with Department of Heath and Mental Hygien Important: If Item 27 is marked other the any Injury or other treasment. G.E.D. 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) William Thomas Briscoe Rose Ellen Powers 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 1382 Mount Zion Marlboro Rd., #403, Lothian, MD 20711 Linda B. Pero/Daughter January 4, 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 1X Burial 2 □ Cremation 3 □ Removal from State 4 □ Conation 5 □ Other (Specify) Maryland Veterans Cem. 2009 2010 Cheltenham, MD 22. Name and Address of Facility Brinsfield-Echols F.H., P.A., 21. Signature of Furieral Service Licenses LOBIT M00817 PO Box 128, Charlotte Hall, MD 20622 Approximate Interval Between Onset and Death Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or leart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Cardio vasular dizense **Physician** Atheroscientic /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Dualto (or as a consequence of) Examiner The law requires that the death certificate be executed burial-trar Due to (or as a consequence of) Division or Vital Records, P.O. Box 68760, physician Physician/Medical the l use as IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy Month Day Year for in the past 12 months? 1 ☐ Yes 2 ☐ No 4☐Pregnant at time of death 5 Other (specify) 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Completed by been signe should be 1 | Yes 2 | No 3 | Probably 4 Unknown Possible. 24a. Was an 24b. Were autopsy findings available prior to completion of cause of death?

1 □ Yes 2 □ No Bactremia autopsy performe page Preelmonia. Aspiration Possible 1□ Yes 2₽ No To the Hospital or Attending Physician: 25. Was case referred to medical 26. Place of Death Check onl one director, Certification: To Be Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No funeral 28a. Date of Injury (Month, Day Year) 28b. Time of Injury 28d. Describe how injury occurred 28c. Injury at Work? 27. Manner of Death 1 Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No death. 2 Accident within 24 hours after death

To the Funeral Director:
completely filled in by the 28f. Location (Street and Number or Rural Route Number, City or Town, State) 6 Could not be determined 3 ☐ Suicide Place of injury - At home, farm, street, factory, office building, etc. (Specify) 4 ☐ Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) (Check only one) and manner stated. 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier D 50653 12-21-2009 wrana.

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State Registrar Road

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

GYAN. C- SURANA

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State
Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ December 28, 2009 12 Noon м Jean Tonkin Brinklev Medical 4a. Facility Name (if not institution, give street and number, 4b. City, Town, or Location of Death Center Walkersville 4c. County of Death **Examiner** Glade Valley Nursing & Rehabilitation Frederick 9. Birthplace (State or Foreign 5. Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth **Funeral** July 24, Year 1926 Hours 1 □ M 2 💢 F 83 West Virginia 214-30-4369 Director Usual Residence of Decedent "natural", or items 23a or 28a-f show edical Examiner must be notified at 10d. Inside City Limits 10c. City, Town or Location 10a. State 10b. County filed within 72 hours after death with the Maryland Director 1 ☐ Yes 2X No Mt. Airy Frederick Maryland 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code U.S.A. Funeral 12774 Barnett Drive 21771 Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 12. Was Decedent Ever in U.S. 11. Marital Status Armed Forces?

1 Yes No If Yes, Give Black, White, etc. þ 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify: Specify. White 3 XWidowed 4 ☐ Divorced Completed the Medical 16a. Decedent's Usual Occupation (Give kind of work done during most of working life_DO NOT useretired) 15. Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) permit. Page 1 and 2 should be filed within 75 Department of Health and Mental Hygiene. Important: If item 27 is marked other than 'any injury or other traumatic event, the Meany injury or other traumatic event. Own Home College (1-4 or 5+) Elementary/Seconday (0-12) Homemaker Be 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Loring Lombard Tonkin Norma Smith Daughter 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) P. O. Box 57, New Market, Maryland 21774 Elizabeth Brinkley Sponseller 20b. Place of Disposition (Name of 20c. Location - City or Town, State 20a. Method of Disposition Date 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) New Market Cemetery Dec. 31, 2009 New Market, MD Signature of Funeral Service Licen ²Keeney and Bustord PA Funeral Home M00255 21701 106 East Church St., Frederick, MD that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, on each line. Approximate Interval Between Onset and Death 23a. Part 1. Enter the disease, or complication shock, or heart failure. List only one caus Immediate Cause (Final Ph_sician/ month holang disease or condition resulting in death) Medical Examiner Sequentially list conditions, Examine Due to (or as a consequence of): if any, leading to immediate
Cause (Disease or iinjury for use as the burial-transi that initiated events resulting in death) Last Due to (or as a consequence of) physician Physician/Medical Records, P.O. Box 68760 IF FEMALE: yes, outcome of pregnancy
Live Birth 2 Fetal death 23b. Was decedent pregnant in the past 12 menths?

1 Yes 2 2 3.No 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ Month Day Year Pregnant at time of death ed by the a detached f 9 Unknown 9 Unknown Hospital or Attending Physician: The law requires that the Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? s been signe should be d Completed by 2 No 3 Probably 4 Unknown pertension 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an Diabetes mellita is certificate has director, page 2 autopsy performed? Yes 2 No 1 Yes 25. Was case referred to medical examiner? Division of Vital 26. Place of Death (Check only one) Be Hospital: 2 No 1 🗌 Yes 1 Inpatient 2 ER/Outpatient 3 IDOA ၉ 4 Nursing Home 5 Residence 6 Other (Specify, this After thi 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred 1 Natural 2 Accident 5 Pending 1 ☐ Yes 2 ☐ No within 24 hours after death.

To the Funeral Director: Af completed filled in by the fu Investigation 6 Could not be Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide determined Medical 1 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifie (Check only on 29d. Date signed (Month, Day, Year) 29b. Signatur of certifier D 5764 3 December 28, 2009

State Registrar

Frederick MD 2

Name and address of person who completed cause of death (Item 23a) (Type, Print)

32. Registrar's

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

			For State Registrar	State of M	aryland		artment of I tificate of I		nd Mental Hy			10571
	Dharisis	/	1. Decedent's Name (First, Midd	, ,					2. Date of Dea) () ()	3. Time of Death
	Physicia Medic	al	Emma Gertrude						12/	21/200		3am M
	Examin	er	4a. Facility Name (if not institution Anne Arundel Mo		r		4b. City, Town, o	r Location of D apolis	Death		nty of Death .e Arur	nde1
	Funeral		5. Social Security Number	6. Sex 7. Ag	ge (In yrs. last birthday) If Under 1 Year I If Under 24 Hrs.					h	9. Birth	place (State or Foreign
	Director		219-16-2312 Usual Residence of Decedent	1 □ M 2 🖾 F	87	Yrs.	Months Days	Hours I	Min. (Month, Da 11/3/	1922	Coun	Md
	and show	or	10a. State 10b. County	y	10c. City,	Town or Loc	ation				- 1	10d. Inside City Limits
	Maryla 28a-f	Director	MD Ann	e Arundel			Harwoo	đ				1 ☐ Yes 🋠 😾 No
	th the	al D	10e. Street and Number 63 Grays Rd.				10f. Zip Code	20776		10g. Citizen		ntry?
	ath wi	Funeral	11. Marital Status	12. Was Decedent I	Ever in U.S.	13. V	1		? (Specify Yes or No-	14.5	USA Race - Americ	can Indian
Maryland 21215-0036	permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Heatth and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.	by	1 ☐ Never Married 2 ☐ Ma 3 🏿 Widowed 4 ☐ Divorce	Armed Forces?		l I	Yes, specify Cuba	an, Mexican, P	uerto Rican, etc.)		Black, White,	
15-(72 hou n "nat ledica	Completed	(Specify only high	ent's Education nest grade completed)		(Give I	lent's Usual Occup kind of work done (O NOT use retired)	during most of	working	16b. Kind of	Business In	dustry
212	within /giene. ner thai		Elementary/Seconday (0-12)	College (1-4 or 8	5+)		Unit Con				Retai1	
pu	be filed on the ked other cevent,	To Be	17. Father's Name (First, Middle,	Last)					Name (First, Middle,			
ryla	should be fill and Mental is marked or aumatic evo	-	Dorsey Brady 19a. Informant's Name/Relations	this (Top a Delta)					na Taylor			
	12 sho alth an 27 is r trau		Douglas Beall	Son					r Rural Route Numbe ${ m od}$, ${ m Md}$ 207		, State, Zip (Code)
Baltimore,	Page 1 and lent of Heal int: If item ? ry or other		20a. Method of Disposition 1 Burial 2 □ Cremation 4 □ Donation 5 □ Other		cer	metery, cren	sition (Name of natory or other place Mem Gare	dens 1	Date 12/23/2009		on - City or To	
Balti	permit, Page 1 a Department of I Important: If ite any injury or of		21. Signature of Fundial Service	Lical see		100	. Name and Addre		Hardesty Annapoli			e, P.A.
			23a. Part 1. Enter the disease, of shock, or heart failure. List	or complications that caused	d the death.							Approximate Interval Between
2	Prysician/		Immediate Cause (Final disease or condition	ACUT	2 m	4000	enous	Lev	Kemia			Onset and Death
	Medical Examiner		resulting in death)	Due to (or as	a conseque	n le of):						
		ner	Sequentially list conditions, translate cause. Enter Underlying	b. Due to (or es	e conseque	noutj:						
8	cuted nd rransit	Examiner	Cause (Disease or linjury that initiated events	c								
_	cate be executed physician and s the burial-transit		resulting in death) Last	Due to (or as	a conseque	nce of):						
92	icate la physis the l	ledical		d								
Box 68	the Hospital or Attending Physician: The law requires that the death certifics thin 24 hours after death. the Puneral Director: After this certificate has been signed by the attending p the Funeral Director after this certificate has been signed by the attending projected filled in by the funeral director, page 2 should be detached for use as in	Physician/N	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 W No 9 ☐ Unknown	23c. If yes, outcome 1 Live Birth 4 Pregnant a 9 Unknown	2 Fetal	death 3	Ectopic pregnand Other (specify)	С у			Date of delive Month	ery Day Year
P.0	requires that the de been signed by the should be detached	by Pr	Part II. Other significant condit	ions contributing to death b	out not resul	ting in the u	nderlying cause gi	ven in Part I.	23e. Did to	bacco use co	ntribute to the	he cause of death?
ds,	quires en sig ould be	ted t							1 🗆	Yes 2 No	3 Pro	bably 4 🗆 Unknown
COL	law re nas be e 2 sho	Completed							24a. Was autor	sy	prior to co	psy findings available impletion of cause of
l Re	i ician: The law certificate has rector, page 2		25. Was case referred to medical						1 🗆 Yes	rmed? 2 V No	death? 1 Yes	2 🗆 No
Vita	ysicia s certi directo	To Be	examiner?	Hospital:	ient 2 🗆 E	R/Outpatien	t 3 DOA Oth	er.	Check only one)	tence 6□C	ther (Specifi	d
of	ng Phys fter this ineral di		27. Manner of Death	28a. Date of inju	ıry 2	8b. Time of injury	28c. Injur work	y at	28d. Describe h			
sion	uttendii death. ctor: Ai y the fu	Certificate;	2 Accident Invest 3 Suicide 6 Could	tigation d not be	uny - At hom	ne farm etre		Yes 2 No		Street and Nue	nhor or Pura	I Doute Museber
Division of Vital Records,	al or Atten s after deaf il Director: ed in by the		4 ☐ Homicide deterr	mined building, etc		io, iaim, suc	ot, lactory, office		City or Tow		iber of nural	l Route Number,
	To the Hospital or Attending Physician: within 24 hours after death. To the Funeral Director: After this certific completed filled in by the funeral director,	Medical	(Check 2 Medical only one) 3 Certifyin	g Physician: To the best of Examiner: On the basis of e g Nurse Practioner: To the	examination a best of my k	and/or invest	igation, in my opinio leath occurred at th	on, death occur e time, date an	rred at the time, date a d place, and due to the	nd place, and e cause(s) and	due to the car manner as st	use(s) and manner stated. ated.
	To the within 2 To the comple		29b. Signature and title of certific	who completed cause of delivery MV	MI)	PS2	2 8 31		29d. Date sign	ned (Month, i	Day, Year) - 21,2009
	5		30. Name and address of person	who completed cause of d	leath (Item 2	3a) (Type, P	rint) gate Ro	cd # 2	30g Am	epslis	MI	2140/
	Stat Registra		31. Date filed (Month, Day, Year) JAN 0 7 2010	32. Registra	ar's Signatu	re			,	*		

DHMH 17 Rev 7/2009

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

		-	_ State	state of Maryland / Dep <i>Ce</i>	ertificate of D			2111	9 42575
			Registrar 1. Decedent's Name (First, Middle, Last)		rimouto or b	- Journ	2. Date of Deat		3. Time of Death
	Physicia Medic		Richard Arnole	Buckler, Sr	•		Decembe	er 11, 20	009 11:57 a M
	Examin		4a. Facility Name (if not institution, give stree	•	4b. City, Town, or			4c. County of	
	Funeral		23696 Lawrence Har 5. Social Security Number 6. Sex	yden Road 7. Age (In yrs. last birthday)	·	ywood If Under 24 Hrs.	8, Date of Birth	St. M	G. Dieth-less (State or Femige
	Director		217-42-2616 TXXM	2 □ F 65 Yrs.	Months Days	Hours Min.	04/22/1	Ye <i>ar)</i> 944	Country) Maryland
	nd now at	ř	Usual Residence of Decedent 10a, State 10b, County	10c. City, Town or L	ocation		_		10d. Inside City Limits
	farylar 8a-f sl tified	Funeral Director	Maryland St. Mary						1 ☐ Yes 2XXNo
	the N	١	10e. Street and Number	3 110114	10f. Zip Code		1	0g. Citizen of Wh	nat Country?
	h with ns 23 nust i	nera	23696 Lawrence Hay		206				S A
	or iten	by Fu	71. Wanta Glaras	Was Decedent Ever in U.S. Armed Forces? 1 □ Yes 2 ☒ No	. Was Decedent of His If Yes, specify Cubar	spanic Origin? (Spe n, Mexican, Puerto l	cify Yes or No- Rican, etc.)		- American Indian, , White, etc.
93	rs afte Iral", (Exan	ed b	0 Dugge 1 4 Dogg	If Yes, Give Year or Dates.	1 ☐ Yes 2 🛣 No	Specify:		Specify:	White
5	72 hou I "natu edica	Completed	15. Decedent's Educa (Specify only highest grade c	ompleted) (Give	edent's Usual Occupa e kind of work done d	ation uring most of worki	ng	16b. Kind of Bus	iness Industry
72	vithin iene.	Con	Elementary/Seconday (0-12)	College (1-4 or 5+)	DO NOT use retired) Mechanic				
b	filed wal Hyg		17. Father's Name (First, Middle, Last)			18. Mother's Name			
ylaı	Ment Ment narked	잍		ckler		Mamie		ısick	
Mar	d 2 shou alth and 27 is n er traum		19a. Informant's Name/Relationship (Type, I Tamala Thompson/Dau		ling Address (Street a				ate, Zip Code) MD 20636
Baltimore, Maryland 21215-0036	permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show amy injury or other traumatic event, the Medical Examiner must be notified at once.		20a. Method of Disposition 1 🛣 Burial 2 □ Cremation 3 □ Ren 4 □ Donation 5 □ Other (Specify)	noval from State 20b. Place of Disp cemetery, cre Trinity	position (Name of ematory or other place Memorial	e) i	.8/2009	20c. Location - C Waldorf	City or Town, State MD
Balt	permit. Departi Import any inj		21. Signature of Fundral Service Course	2	22. Name and Addres Brinsfield 30195 thr	s of Facility d-Echols ee Notch	Funeral Rd., Cha	Home, P	.A. Hall, MD 20622
			23a. Part 1. Enter the disease, or complicat shock, or heart failure. List only one ca	use in each line.		g, such as cardiac c	r respiratory arre	st,	Approximate Interval Between
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	Examiner		Y. Fales	Due to (or as a contequence of):					
		iner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying	Due to (or as a consequence of):					250
	icate be executed physician and s the burial-transit	Examiner	Cause (Disease or iinjury that initiated events c resulting in death) Last	Due to (or as a consequence of):					
0	be ex sician burial	edical	d	,					
8760	ificate ng phy as the	Medi	IF FEMALE:						
Division of Vital Records, P.O. Box 68	To the Hospital or Attending Physician: The law requires that the death certification 24 hours after death. To the Funeral Director. After this certificate has been signed by the attending prompleted filled in by the funeral director, page 2 should be detached for use as	Physician/M	23b. Was decedent pregnant 23c.		Ctopic pregnanc Other (specify)	у		23d. Date Mont	of delivery th Day Year
Ö.	v requires that the de been signed by the should be detached	y Ph	Part II. Other significant conditions contrib	outing to death but not resulting in the	underlying cause giv	en in Part I.	23e. Did tob	pacco use contrib	oute to the cause of death?
S,	uires t n sign uld be	ed by				17	1 X Y	es 2 🗆 No 3	3 ☐ Probably 4 ☐ Unknown
COL	law req has bee e 2 sho	Completed					24a. Was ar autops perforr	sy pri	ere autopsy findings available ior to completion of cause of eath?
<u>~</u>	ician: The law certificate has rector, page 2 s		25. Was case referred to medical		26 DI	ace of Death (Check	1 🗆 Yes		Yes 2 No
Vita	nysician: 1 nis certifica director, p	To Be	examiner? 1 □ Yes 2 No	oital: 1 ☐ Inpatient 2 ☐ ER/Outpati	Othe	ar.		ence 6 🗌 Other	(Specify)
n of	ding Phy th. After this funeral o		27. Manner of Death 1 Natural 5 Pending 2 Accident Investigation	28a. Date of injury (Month, Day, Year) 28b. Time injury	of 28c, Injury work	at		w injury occurred	
ivisio	I or Attend s after death Director; / d in by the f	Certificate:	3 Suicide 6 Could not be	28e. Place of Injury - At home, farm, s building, etc. (Specify)	treet, factory, office		28f. Location (Sta City or Town		or Rural Route Number,
	To the Hospital of within 24 hours a To the Funeral D completed filled i	Medical	(Check 2 Medical Examiner:	n: To the best of my knowledge, death On the basis of examination and/or inve actioner: To the best of my knowledge	estigation, in my opinic	n, death occurred at	the time, date an	d place, and due t	to the cause(s) and manner stated.
	To the within comp	2	29b. Signature and title of certifier	- Sto Society Wilder	29c. License	number	, 2	9d. Date signed ((Month, Day, Year)
	i .		1 1/10		1000	5575	/	12-13	5-07
Al	س		30. Name and address of person who comp Jenniter Schmidt,	leted cause of death (Item 23a) (Type	, Print) ercnants L:	n. Leonar	dtown.	MD 20650	1
حار ا	Sta	- 4	31. Date filed (Month, Day, Year)	32. Registrar's Signature		, 2001141			
	Registra	alî'	DEC & I A	cerem p.	7				

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

		-	For State Registrar	State of Ma	arylanc		rtment of h tificate of L		ind Mental Hy	gien Reg. N	2000	42576
			1. Decedent's Name (First, Middle, Las	st)					2. Date of De	ath		3. Time of Death
	Physicia Medic		Josephine Laur	inda Ber	g				Decemb	er 1	8, 2009	10:30 p.M.
	Examin		a. Facility Name (if not institution, give	street and number)			4b. City, Town, o	r Location of	Death	4	c. County of Dea	th
	-1		St. Mary's Hospit	al			Leonardt If Under 1 Year		<u> </u>		St. Mary	
	Funeral Director		219–48–6759	ex □ M 2 🗓 F	(In yrs. las	t birthday) Yrs.	Months Days	If Under 2 Hours	Min. 8. Date of Bir (Month, Date of All 1997) 04/25/	th 1948	9. Bir	thplace (State or Foreign untry) y land
	lt ov	١	Usual Residence of Decedent 10a, State 10b, County		10c City	Town or Loc	ation		-			10d. Inside City Limits
	arylan a-f sh fied a	cto		,								1 ☐ Yes 2 🔯 No
	or 28	ا ۵	Maryland St. Mary 10e. Street and Number	S	Leona	rdtown	10f. Zip Code			10a. C	Citizen of What Co	
	with the 23a of st be	Funeral	22591 Point Looke	ut Road			20650			-	ted Sta	
	eath v	Ē	11. Marital Status	12. Was Decedent E	ver in U.S.	13. W	as Decedent of H	lispanic Origi	in? (Specify Yes or No- Puerto Rican, etc.)		14. Race - Ame	erican Indian,
36	permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Insperment of Health and Montal Hygiene Insperment of Health and Montal Hygiene. Insperment of them 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.	by	1 Never Married 2 Married	Armed Forces? 1 ☐ Yes 2 🔀 I If Yes, Give	No	1	Yes 2 X No		Fuerto nicari, etc.)		Black, Whit	
Ö	ours a	Completed	3 Widowed 4 Divorced	Year or Dates.	-	16a Donad	ent's Usual Occup	action		4.00	l Wh	ite
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bu	filed val Hyg	Be c	17. Father's Name (First, Middle, Last)					18. Mother	r's Name (First, Middle	, Maidei	n Surname)	
<u> </u>	ld be Ment arke	욘	Joseph Lang					Eunio	ce Laurinda	a Ri	dge11	
Ja.	shou and is m		19a. Informant's Name/Relationship (7	ype, Print)					or Rural Route Number			
<u>d</u>	and 2 Health		Harold I. Berg. S	r./Husband			Point L	<u>ookout</u>	t Road, Le		dtown. I	
Ž	nt of h		1 🕅 Burial 2 🗆 Cremation 3		Firs	metery, crem t Fria	atory or other place	сө)	Date 2/24/2009	20C.	Location - Gity of	Town, State
Baltimore	artme artme ortani injury		4 ☐ Donation 5 ☐ Other (Speci 21. Sign 📆 ♠ Fineral Service Liven	(b)	Meth	odišť`	Name and Addre	Cem. 12	2/24/2009	Rid	ge, Mar	yland
	Depti Impo		Edward N. Brins	field, Jr.		052 22	955 Holl	ywood	Road, Leon	nard		•
			23a. Part 1. Enter the disease, or com shock, or heart failure. List only of	plications that caused one cause on each line	the death.	Do not ente	r the mode of dyir	ng, such as c	ardiac or respiratory a	rrest,		Approximate Interval Between
	Pnysician/	1	Immediate Cause (Final disease or condition resulting in death)	a Adu	NR	li	NOV.	Yau	lure			Onset and Death
	Medical Examiner		resulting in dealing	Due to (or as a	conseque	ence of):	di	ach	21201			
		ner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying	b. Due to (or as a	conseque	ence of):		7 00	030			
	uted d ansit	Examiner	cause. Enter Underlying Cause (Disease or iinjury that initiated events	6								
	ate be executed physician and the burial-transit	E	resulting in death) Last	Due to (or as a	conseque	ence of):						
09,	ate be hysici	edical	•	d								
387	artifice ling p	/Me	IF FEMALE:	23c. If yes, outcome of	of pregnan	CV		-				
P.O. Box 687	ath ce attenc for us	Completed by Physician/M	23b. Was decedent pregnant in the past 12 months?	1 Live Birth 4 Pregnant at	2 🗌 Fetal	death 3	Ectopic pregnan Other (specify)	су			23d. Date of de Month	Day Year
ă	ne deg	ysi	1 Yes 2 No 9 Unknown	9 Unknown		,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,						
O	that the ned by deta	y PI	Part II. Other significant conditions	contributing to death be	ut not resu	lting in the u	nderlying cause gi	iven in Part I.	23e. Did	tobacco	use contribute to	o the cause of death?
5	uires an sign	ed	Cardioni	10 par	u	1/1 0			1×	Yes	2 □ No 3 □ F	Probably 4 🗆 Unknown
2 100	tw required as bee	plet	Pulmon	ary He	B	WIL	WHO	U	24a. Was	s an opsy		utopsy findings available completion of cause of
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Š	hysic this co	၉	1 🗆 Yes 2 🕽 🐪 🔾			R/Outpatien		4 □ Nui	rsing Home 5 Res			cify)
9 5	ding F h. After funer	Certificate:	27. Manner of Death 1 □ Natural 5 □ Pending	28a. Date of injur (Month, Day		28b. Time of injury	28c. Injur wort M 1 \(\(\triangle\)	ry at k?]Yes 2 □	28d. Describe	how inju	ury occurred	
Z in	Atten r deat ctor: y the	ıţį [2 Accident Investigatio 3 Suicide 6 Could not to 4 Homicide determined	28e. Place of Inju		ne, farm, stre		100 2		(Street a	and Number or Ru	ıral Route Number,
Division of Vital Becords	al or / s after Il Dire		4 - Homiciae aeterminea	building, etc	. (Specify)				City or To	wn, Sta	te)	
Josep hine	To the Hospital or Attenting Physician: The law requires that the death certific within 24 hours after death. Within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending to completed filled in by the funeral director, page 2 should be detached for use as	Medical	(Check 2 Medical Exam	sician: To the best of liner: On the basis of ex	kamination	and/or invest	igation, in my opini	ion, death oc	curred at the time, date	and place	ce, and due to the	cause(s) and manner stated.
10		Ž	only one) 3 L Certifying Nur 29b, Signature and title of certifier	se Practioner: To the	pest of my	knowledge, c	leath occurred at the 29c. Licens		ario piace, and due to t		e(s) and manner as Date signed (Moni	
	معلم		▶ (Raldur)	NOON			DA	523	381)	2/21	109
•	it bus		30. Name and address of person who	completed cause of de			rint)	0 .	mandta	M =	vilon i	20650
	Stat	te	31. Date filed (Month, Day, Year)	32, Registre			Numbra	ν _Lec	nardtown,	mar	yrand 2	20650
	Registra		DEC 25	2 2009	usa,	A	fall					

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene - State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Month 2009 2:55 Fidelis Bassford December Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death St. Mary's Hospital St. Mary's Leonardtown Social Security Number If Under 1 Year If Under 24 Hrs. 9. Birthplace (State or Foreign 6. Sex 7. Age (In yrs. last birthday) 8. Date of Birth **Funeral** 1 M 2 K F Months Days Hours Min. 06/23/192 Director 577-24-4620 88 Maryland Usual Residence of Decedent r than "natural", or items 23a or 28a-f shov the Medical Examiner must be notified at 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director 1 Yes 2X No St. Mary's <u>Maryland</u> Leonardtown 10f. Zip Code 10g. Citizen of What Country? 22680 Cedar Lane Court #3207 20650 USA death 12. Was Decedent Ever in U.S Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian ģ 1 ☐ Yes 2 🛣 No If Yes, Give 1 Never Married 2 Married 1 ☐ Yes 2 K No Specify: Completed 3 X Widowed 4 Divorced White Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business Industry (Specify only highest grade completed) al Hyglene. Elementary/Seconday (0-12) College (1-4 or 5+) Homemaker Own Home Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) and Mental F permit. Page 1 and 2 should be file Department of Health and Mental Important: If item 27 is marked of any injury or other traumatic eve 2 Fulton Abell, Sr. Noema Wathen 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Frank E. Taylor/Nephew 21651 Rosebank Rd., Leonardtown, MD 20650 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place)
St. Aloysius 20c. Location - City or Town, State 1 🔀 Burial 2 🗆 Cremation 3 🗆 Removal from State 12/31/2009 Leonardtown, MD 4 Donation 5 Other (Specify) 21. Sign are of ceral see then 22. Name and Address of Facility Brinsfield Funeral Home, P.A. Edward N. Brinsfield, Jr. M00052 22955 Hollywood Rd., Leonardtown, MD 20650 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Pnysician CARDIORESPIRATIONY ARLEST disease or condition Medical resulting in death) Due to (or as a consequence of) Examiner PULMONARY EDEMA ACUTE Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examiner Due to (or as a consequence of). CONGESTIVE HEART FAILURE Cause (Disease or iinjury that initiated events attending physician and for use as the burial-tran Due to (or as a consequence of): resulting in death) Last Physician/Medical law requires that the death certificate be IF FEMALE: 23c. If yes, outcome of pregnancy

1 Live Birth 2 Fetal death
4 Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy
5 Other (specify) in the past 12 months? Month detached the 9 Unknown s been signed to should be det Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 🗌 Yes 2/K No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of 24a. Was an p ge 2 autopsy Hospital or Attending Physician: T e performed' death? 1 ☐ Yes 2 ₽ No funeral director. 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? ၉ 1 ☐ Yes 2 Ѿ No Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☑ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred 1 Natural 5 \square Pending after death. Director: Aft 1 Yes 2 No Accident Investigation 3 Suicide
4 Homicide 6 Could not be To the Hospital or Atte within 24 hours after de To the Funeral Directo completed filled in by th 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Saltimore, Maryland 21215-0036

955 Ford

5 Records,

Division of Vital

Box 68760

PO

State Registrar

Luiz Malini, M.D. 31. Date filed (Month, Day, Year)

DFC 29

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

(Check only one)

29b. Signature and title effectifie

Leonardtown, MD 20650 32. Registrar's Signature

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

069683

29d. Date signed (Month. Dav. Year)

Baltimore, Maryland 21215-0036

Box 68760,

P.O.

Division of Vital Records,

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death Reg. No. 2. Date of Death 1. Decedent's Name (First, Middle, Last) BROVES Month (2 og Og **Physician** LLEN /Medical 4c. County of Death
PRINCE GEORGE'S 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) Examiner FORT WASHINGTON 9505 CALTOR LANE Birthplace (State or Foreign Country) If Under 1 Year I If Under 24 Hrs. 5. Social Security Number 7. Age (In yrs. last birthday, 8. Date of Birth (Month, Day, Year) **Funeral** Days Min 61 14 1948 MISSOURI 346-42-9191 Director Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 10b. County 10a State 28a-f show th and Mental Hygiene.
7 is marked other than "natural", or items 23a or 28a-f shov traumatic event, the Medical Examinar must be notified at FORT WASHINGTON PRINCE GEORGE'S 1 XYes 2 ☐ No MD Director 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number USA 20744 9505 CALTOR LANE Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ∐Yes 2∑No If Yes, Give Year or Dates: 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian. Black, White, etc. Pages 1 and 2 should be filed within 72 hours after 1 Never Married 2 Married 1 □Yes 2 No BLACK Specify: ş 3 Widowed 4 Divorced Be Completed 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) GOVERNMENT FINANCE OFFICER 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) BENNETT MARGIE MOSS JOHN ပ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) CALTOR LANE FORT WASHINGTON, MARYLAND 20744 other t WILLIE BROOKS JR./HUSBAND 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) Department of H Important: If iter any Injury or oth once. 20a Method of Disposition 1 ☐ Burial 2 🎇 Cremation 3 ☐ Removal from State RIVERDALE, MARYLAND 12/21/09 4 ☐ Donation 5 ☐ Other (Specify) RIVERDALE CREMATORY 22. Name and Address of Facility J. B. JENKINS FUNERAL HOME 21. Signature of Funeral Service Licensee 7474 LANDOVER ROAD LANDOVER, MARYLAND Approximate Interval Between Onset and Death 23a. Part1. Enter the disease, occomplications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. METASTATIC Immediate Cause (Final CALUNG WIRELY **Physician** disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examine To the Hospital or Attending Physician: The law requires that the death certificate be executed use as the burial-trar Due to (or as a consequence of): attending physician Physician/Medical IF FFMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Month Day Year in the past 12 months? 5 Other (specify) been signed by the should be detached 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 3 Probably 4 Unknown 2 🗌 No Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 □Yes 2√□No 24a. Was an cate has page 2 s perform certificate 1 ☐ Yes 26. Place of Death (Check only one) 25. Was case referred to medical Medical Certification: To Be Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA this funeral 28c. Injury at Work? 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of 28d. Describe how injury occurred 1 Natural
2 Accident 5 Pending s after death.

I Director: Af in by the fur 1 ☐ Yes 2 ☐ No investigation 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 6 Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 ☐ Suicide determined 4 Homicide 24 hours Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

[2] Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifier

A L 10

31. Date filed (Month, Day, Year)
UEC 2 2 2009

Name and address of person

CHMEL

who completed cause of death (Item 23a) (Type, Print)

- 32. Registrar's Signature

Registrar

EFENSE

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 🤈 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month 2009 Louis Bachrach 6:15 РΜ December Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Collington Episcopal Life Care Mitchellville Prince George's Social Security Number If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) April 17, 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign **Funeral** 1 X M 2 □ F Months Days Hours Min. Director 004-46-0935 91 1918 Maynard, Usual Residence of Decedent show 10a. State 10b. County 10c. City, Town or Location ral", or items 23a or 28a-f sho Examiner must be notified at 10d. Inside City Limits Director 1 X Yes 2 No Maryland Prince George's Mitchellville 10e. Street and Number 10f, Zip Code 10g, Citizen of What Country? Funeral 10450 Lottsford Road, #3104 20721 USA death 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian. Completed by 1 Never Married 2 Married 1 X Yes If Yes, Give 2 🗌 No within 72 hours after Maryland 21215-0036 1 Yes 2 No Specify: "natural", Specify: White 3 X Widowed 4 Divorced WWII Year or Dates. the Medical Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) al Hygiene. College (1-4 or 5+) 5+ Elementary/Seconday (0-12) Medical Doctor Private Practice other traumatic event, Be permit. Page 1 and 2 should be filed Department of Health and Mental Hy Important: If item 27 is marked oth any Injury or other traumatic event 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ည Isaac Bachrach Esther Kramer 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 6253 Cardinal Lane, Columbia, MD 21044 George Bachrach / Son Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 Durial 2 M Cremation 3 D Removal from State Metropolitan Crematory 12/23/2009 4 Donation 5 Other (Specify) Alexandria, Virginia 21. Signature of Funeral Service Licensee 22. Name and Address of Facility 4739 Baltimore Avenue Lay Gasch's Funeral Home, P.A. Hyattsville, MD 20781 RAY TRESONS 1. Enter the decase, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate shock, or heart failure. List only one cause on each line Interval Between Onset and Death 1 Week Immediate Cause (Final Physician Cerebrovascular Accident disease or condition Medical resulting in death) Due to (or as a consequence of): Examiner Sequentially list conditions, Due to (or as a consequence of). if any, leading to immediate sician and burial-transit Exami executed Cause (Disease or linjury that initiated events Due to (or as a consequence of): resulting in death) Last physician Physician/Medical that the death certificate be Box 68760 attending physi IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ in the past 12 months? Month Day Year Pregnant at time of death signed by the a 2 No g Unknown P.0. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Alzheimer's Disease, Coronary Artery Disease Records, Hospital or Attending Physician; The law requires Completed 1 ☐ Yes 2 🖾 No 3 ☐ Probably 4 ☐ Unknown should 24b. Were autopsy findings available prior to completion of cause of death? Hypertension, Hypercholesterolemia 24a. Was an s certificate has the director, page 2 standard autopsy perform Yes 2 X No 1 ☐ Yes 2 ☐ No After this certification funeral director, r Division of Vital 25. Was case referred to medical Be 26. Place of Death (Check only one) Other: 4 \square Nursing Home 5 \square Residence 6 \boxtimes Other (Specify 1 🗌 Yes 2 🛚 No 은 1 Inpatient 2 ER/Outpatient 3 DOA 27. Manner of Death 28b. Time of 28a. Date of injury 28c. Injury at Certificate: 28d. Describe how injury occurred (Month, Day, Year) 1 X Natural 5 Pending work' To the Hospital or Attendin, within 24 hours after death.

To the Funeral Director: Aft completed filled in by the fur 1 ☐ Yes 2 ☐ No М Accident Investigation Suicide 6 Could not be 28e, Place of Injury - At home, farm, street, factory, office 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined building, etc. (Specify) Medical

54,

DEC 2 3 2009 Date filed (Month, State Registrar

29a, Certifier

only one

29b. Signature and title of certifie

Don H. Yablonowitz, 7404 Executive Place, Suite #502, Lanham, MD 20706

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

🖾 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated

29c. License number

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

D25079

29d. Date signed (Month, Day, Year) 12/22/2009

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death Reg. No. 2 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month Physician/ 2009 Christine Alberta Bradley Dec. Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death Examiner 4c. County of Death 13107 Foxbox Drive Upper Marlboro Prince George's 5. Social Security Number Year If Under 24 Hrs. 8. Date of Birth 7. Age (In vrs. last birthday) **Funeral** (Month, Day, Months Days Hours Yea 1 □ M 2 🖾 F 916 Wakefield, VA Yrs Director 222-05-3047 Dec. Usual Residence of Decedent er than "natural", or items 23a or 28a-f show the Medical Examiner must be notified at 10c. City, Town or Location within 72 hours after death with the Maryland 10a State 10b. County Director Maryland Prince George's Upper Marlboro 10f. Zip Code 10e. Street and Number 10g. Citizen of What Country? Funeral 13107 Foxbox Drive 20774 United States 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian 11. Marital Status Armed Forces? Black, White, etc. 1 Never Married 2 Married by Maryland 21215-0036 If Yes, Give Year or Dates 1 Yes 2 No Specify: Completed 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life, DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) 8th Private Homemaker Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) t. Page 1 and 2 should be filed thent of Heaith and Mental Hi rtant: If item 27 is marked ot ijury or other traumatic even ပ္ Royal Melford Warren Hattie Epps 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Department of Health a Important: If item 27 is any injury or other trau 9901 Quiet Glen Court, Springdale Md. Christine B. Kennedy/Daughter Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State December cemetery, crematory or other place) 1 🗷 Burial 2 🗌 Cremation 3 🗌 Removal from State 4 Donation 5 Other (Specify) 18, 2009 Lincoln Cemetery Brentwood, Maryland ature of Auneral Service Licens 22. Name and Address of Facility Stewart Funeral Home, Inc. 4001 Benning Rd. NEWashington, DC 23a. Part 1 Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Immediate Cause (Final Physician/ me disease or condition Medical resulting in death) as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examine Due to (or as a consequence of): certificate be executed the burial-transit Cause (Disease or iinjury that initiated events Due to (or as a consequence of): resulting in death) Last physician Physician/Medical Box 68760 IF FEMALE; use 23c. If yes, outcome of pregnancy 1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy 5 Other (specify) ____ in the past 12 months? that the death Month Pregnant at time of death been signed by the a should be detached t 1 ☐ Yes ∠ ⊑ 9 ☐ Unknown P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 Yes 2 No 3 Probably 4 Unknown Records, Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy yes 2 N 1 Yes of Vital Hospital or Attending Physician: 25. Was case referred to medical Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 A Residence 6 Other (Specify) 1 Yes 2/ No Certificate: To 1 Inpatient 2 ER/Outpatient 3 DOA After this funeral 27. Manne of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 Natural n 24 hours after death. e Funeral Director: After the function is the function of the function is the function in the functio 5 Pending Division Accident Suicide 1 🗆 Yes 2 🗌 No Investigation Could not be Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated The decrease Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. within 2 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year)

10:10 A M

9. Birthplace (State or Foreign

Black

20019

Dav

20707

Year

Onset and Death

10d. Inside City Limits

1 X Yes 2 No

CR 6

State Registrar

Darryl A. Hill, M.D. FACP 13635 Baltimore Ave. South Lakes Ofc. Pk. 31. Date filed (Month, Day, Year) DEC 2 3 2009

30. Name and address of person who

muleted cause of death (Item 23a) (Type, Print)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 2000 Certificate of Death 3. Time of Death 2. Date of Death Decedent's Name (First, Middle, Last) Month 1:13 РΜ 2009 December Regina Louisa Brown 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (if not institution, give street and number) Prince George's Clinton Southern Maryland Hospital 9. Birthplace (State or Foreign If Under 1 Year If Under 24 Hrs. 8. Date of Birth . Age (In yrs. last birthday) Social Security Number Months Days Hours Chicago, IL 1 M 2 X F 35 October Yrs 356-62-9663 Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 10a. State 1 X Yes 2 No Brandywine Prince George's Maryland 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number USA 20613 12701 Lusbys Lane Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 12. Was Decedent Ever in U.S. Armed Forces? 11. Marital Status Black, White, etc. 1 Yes 2 No 1 Never Married 2 Married 1 Yes 2 No Specify: Specify: Black 3 Widowed 4 Divorced Year or Dates 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business Industry 15. Decedent's Education (Specify only highest grade completed) College (1-4 or 5+) Legal Elementary/Seconday (0-12) Law Clerk 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Rosemary Brown Samuel O. Bassey 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 12701 Lusbys Lane, Brandywine, MD 20613 Ronda Brown / Sister 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition ☐ Burial 2 🖾 Cremation 3 ☐ Removal from State Alexandria, Virginia 12/23/2009 Metropolitan Crematory 4 Donation 5 Other (Specify) 22. Name and Address of Facility 4739 Baltimore Avenue 21. Signature of Funeral Service Licensee Hyattsville, MD 20781 Gasch's Funeral Home, P.A. al 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Interval Between shock, or heart failure. List only of Onset and Death Immediate Cause (Final disease or condition resulting in death)

Physician/ Medical **Examiner**

attending physician and for use as the burial-transit

the

signed by

should be detached

page 2 s this certificate has

after death the

24 hours

within 2 To the I

completed filled in by

Completed by

Be

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Certificate:

Medical

Physician/

Medical

Director

Funeral

þ

Complet

Be

Examiner

Funeral

Director

filed within 72 hours after death with the Maryland al Hygiene. at Hygiene. d other than "natural", or items 23a or 28a-f shov

Baltimore, Maryland 21215-0036

the Medical Examiner must be notified

or other traumatic event,

should be file h and Mental F is marked of

permit. Page 1 and 2 sh Department of Health ar Important: If item 27 is any injury or other trau

"natural", or items

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or linjury that initiated events resulting in death) Last

ne ca	use on each line.
a	Metastatic breast cancer Due to (or as a consequence of):
b. =	Due to (or as a consequence of):
C. =	Sep Sis Due to (or as a consequence of):
d	

Examine Physician/Medical IF FEMALE: 23b. Was decedent pregnant in the past 12 months?
1 Yes 2 No g Unknown

SC.	IT	yes, outcome or pregnancy
	1	Live Birth 2 Fetal de
	4	Pregnant at time of deatl
	_	T the Law account

3 Ectopic pregnancy 5 Other (specify)

23d. Date of delivery Month Day

Year 23e. Did tobacco use contribute to the cause of death?

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

1 🗆 Yes	2 🗆	No 3	☐ Pro	bably	4 Unknown
4a. Was an autopsy performed	- 1	pr de	ere auto ior to co ath? Yes	mpleti	dings available on of cause of No

sy findings available 2 🗌 No

25. Was case referred to medica 1 Yes 2 No 27. Manner of Death

1 Natural

2 Accident
3 Suicide

4 Homicide

29a, Certifier

1 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of injury (Month, Day, Year) 5 Pending Investigation 6 Could not be

28b. Time of 28c. Injury at injury 1 ☐ Yes 2 ☐ No 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

Other: 4 Nursing Home 5 Residence 6 Other (Specify) 28d. Describe how injury occurred

2

28f. Location (Street and Number or Rural Route Number, City or Town, State) Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check 29b. Signature and title of certifier

determined

26. Place of Death (Check only one)

29d. Date signed (Month, Day, Year)

and address of person who completed cause of death (Item 23a) (Type, Print)

Surratts Rd.C

State

Hospital or Attending Physician: The law requires that the death certificate be Division of Vital Records, P.O. Box 68760

31. Date filed (Month, Day, Year) DEC 2 3 2009

Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Day Month Year **Physician** BROWNING O8:30 M 2008 Robert 22 /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner Prince George's Prince George's Hospital Cheverly If Under 1 Year Months Days If Under 24 Hrs. 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) 5. Social Security Number 6. Sex **Funeral** Hours 1 X M 2 □ F 91 005-16-2918 6/27/1918 Washington, DC Director Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 10a State 10b. County 28a-f show permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryla Department of Health and Mental Hygiene.
Important: If item 27 Is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, it is Mouteal Examination ust be notified as once. 1X Yes 2 □ No Director MD Prince George's Mitchellville 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number 20721 U.S.A. 10450 Lottsford Road Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 X Yes 2 ☐ No 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian 11. Marital Status Black, White, etc. 1 X Yes 2 □ No If Yes, Give Year or Dates: WWII 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify Specify: þ White 3 X Widowed 4 □ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) Coast Guard Naval Architect 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Ruth Millard Horace Browning ၉ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 21613 309 Glenburn Avenue, Cambridge, MD Barbara Harp / Daughter 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20a. Method of Disposition 1 ☐ Burial 2 ☑ Cremation 3 ☐ Removal from State 12/24/09 4 ☐ Donation 5 ☐ Other (Specify) Alexandria, Virginia Metropolitan Crematory 21. Signature of Funeral Service Licensee 22. Name and Address of Facility 4739 Baltimore Avenue Joeph 23a. Part 1. Enter the disease, or complications that caused the death. Shock, or heart failure. List only one cause on each line.

Gasch's Funeral Home, PA Hy

Do not enter the mode of dying, such as cardiac or respiratory arrest, Hyattsville, MD 20781 Approximate Interval Between Onset and Death DEMENTIA Immediate Cause (Final disease or condition resulting in death) **Physician** /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examine FIbrillation Hospital or Attending Physician: The law requires that the death certificate be executed attending physician and for use as the burial-tran Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, Pneumonia. Physician/Medical 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Day in the past 12 months? Pregnant at time of death 5 ☐ Other (specify) 1 ☐Yes 2 ☐No ed by the detached 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part t. þ 1 ☐ Yes 2 🛣 No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an s certificate has the lirector, page 2 s performe 1 ☐ Yes 2 No 1 ☐Yes 2 ☐No this certifical 25. Was case referred to medical examiner? Be 26. Place of Death (Check onl one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To After this Date of Injury (Month, Day, Year) 27. Manner of Death 28b. Time of Injury 28d. Describe how injury occurred 28c. Injury at Work? 1 Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident after death Director: d in by the f 6 ☐ Could not be 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide within 24 hours aft

To the Funeral Di

completely filled in 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical (Check only one) and manner stated. 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifier 18982000 Andell aims mukemil 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) on, ella pora Mukemil 6005 Landover Rd., S-3, Cheverly, MD 20785 31. Date filed (Month, Day, Year DEC 2 3 2009 State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Month : 29 PM Virginia Lee BARGER December Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** 4c. County of Death Washington County Hospital Washington Hagerstown 8. Date of Birth (Month, Day, Year) Aug. 24 1918 Social Security Number 6. Sex If Under 1 Year If Under 24 Hrs. 9. Birthplace (State or Foreign **Funeral** Age (In yrs. last birthday) Min. 1 □ M 2 💢 F Hours Country) West Director 214-16-1104 91 Virginia Usual Residence of Decedent 28a-f shov 10a. State 10b. County 10c. City, Town or Location Examiner must be notified at 10d. Inside City Limits Director 1 X Yes 2 No Maryland Washington Hagerstown ō 10e, Street and Number 10f. Zip Code 10g, Citizen of What Country? items 23a Funeral 205 Devonshire Road USA 21740 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ※ No If Yes, Give Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, "natural", or 1 Never Married 2 X Married Completed by Maryland 21215-0036 within 72 hours after 1 ☐ Yes 2 🔀 No Specify: 3 Widowed 4 Divorced Specify: White Year or Dates the Medical 15. Decedent's Education 16a. Decedent's Usual Occupation 16b, Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) 2 should be filed within 72 lih and Mental Hygiene. 7 is marked other than "r Elementary/Seconday (0-12) College (1-4 or 5+) 12 0 Homemaker Her own home permit. Page 1 and 2 should be filed w Department of Health and Mental Hygi Important: If item 27 is marked othe any injury or other traumatic event, ? Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ည Ercelle Franklin Ambrose Maude Belle Kidwiler 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Snowfall Dr., Manassas, Barry Barger - Son Virginia 21002 Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Rose Hill Cemetery 12/28/09 Hagerstown, Maryland Signature of Funeral Service Licenses 22. Name and Address of Facility Minnich Funeral Home . Wester tred 415 E. Wilson Blvd. Hagerstown, Md. 21740 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final MASSIVE Physician/ STROILE -Situl disease or condition Medical resulting in death) Due to (or as a consequence of) Examiner HUBERTONSION Sequentially list conditions, Examine If any, leading to immediate cause. Enter Underlying Coronany Cause (Disease or iinjury that initiated events sician and burial-trans Due to (or as a consequence of) resulting in death) Last attending physician I for use as the buria Physician/Medical that the death certificate be Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregna 5 ☐ Other (specify) Ectopic pregnancy in the past 12 months?
1 ☐ Yes 2 No
9 ☐ Unknown Month Pregnant at time of death signed by the a d be detached f 9 Unknown P.O. Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Division of Vital Records, or Attending Physician: The law requires 1 Yes 2 No 3 Probably 4 Y Unknown Completed Were autopsy findings available prior to completion of cause of 24a. Was an page 2 s has autopsy performed? Yes 2 2 N death? 1 Yes 2 No 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? 2 🎢 No Other: 4 \(\sum \) Nursing Home 5 \(\sum \) Residence 6 \(\sum \) Other (Specify) မ 1 Inpatient 2 ER/Outpatient 3 IDOA this n 24 hours after death.

• Funeral Director: After th
pleted filled in by the funeral Certificate: 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 Natural 5 Pending 1 Yes Accident Investigation 6 Could not be 3 Suicide 4 Homicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined

14H-8 State

Hospital

npleted 1

within 2 To the F complet

Medical

29a. Certifier

only one)

31. Date filed (Month

3

ed

MI)

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

QAD (R

29b. Signature and title of certifier

1190 mr

egistrar's Signatur

🗷 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

AETWA

Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29c. License number

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

4656

RUMIS

29d. Date signed (Month, Day, Year)

HAGINIVEN

009

			For State Registrar	State of Maryland		tificate of			g. No.	
	Physicia	an	1. Decedent's Name (First, Middle, Last,	1	12	2 100		2. Date of Death Month	Day Year	3. Time of Death
and the second	Physicia /Medic		Dory		D	rooks	Lastin of Dooth	December	4c. County of Deat	1 0
	Examin	er	4a. Facility Name (If nd institution, give Tho, Tohas Ho	pKIN HOSPite	al	Balti	MDCA CT	ty	4c. County of Deat	
	Funeral		Social Security Number 6. Security Number	7. Age (In yrs. I		If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day,	9. Birt	thplace (State or Foreign buntry)
	Director		215-38-4090	M 2□F 69	Yrs.				1940 Ma	
	land ow		Usual Residence of Decedent 10a. State 10b. County	10c. City	y, Town or Lo	cation				10d. Inside City Limits
	a-fsh	ctor	MD Howard	E1	kridq	e				1 X Yes 2 No
	or 28	Dire	10e. Street and Number			10f. Zip Code		10	g. Citizen of What Co	ountry?
	s 23a	eral		1d Rd #L-2 12. Was Decedent Ever in U.S	6 12 1	21075		pocify Vas or No.	USA 14. Race - Ame	erican Indian
"	fter de ritem inner	Funeral Director	11. Marital Status 1 ☐ Never Married 2 ☐ Married	Armed Forces? 1 ☐Yes 2 ☑ No If Yes, Give			lispanic Origin? (Sp an, Mexican, Puerto	Rican, etc.)	Black, White	
03	should be filed within 72 hours after death with the Maryland nd Mental Hyglene. marked other than "natural" or items 23a or 28a-f show imatic event, the Medical Examinar must be notified at	d by	3 Widowed 4 Divorced	If Yes, Give** Year or Dates:		□Yes 2√∑No	Specify:			lack
15-("natu	Completed	15. Decedent's Edu (Specify only highest grad	cation e completed)	16a. Deced	lent's Usual Occup kind of work done	oation during most of work d)		6b. Kind of Business	Industry
12	withir jene. r than the Me	omo	Elementary/Secondary (0-12)	College (1-4or 5+)		nsit Op		I .	Private	Industry
br	al Hygi other vent, tl	Be C	17. Father's Name (First, Middle, Last)			HOLE OP		e (First, Middle, M		
ylaı	should be I and Mental marked o umatic eve	To E	Dory W. Brooks					Stepney		
Maryland 21215-0036	nd 2 sho alth and 27 is ma r trauma	1	19a. Informant's Name/Relationship (T) David Brooks/S	•					City or Town, State, Elkridg	
	L L L L L L L L L L L L L L L L L L L		20a. Method of Disposition	20b. P		sition (Name of natory or other place			20c. Location - City or	
Baltimore,	0 0 to 5		1 ☐ Burial 2 ☐ Cremation 3 ☐ F 4 ☐ Donation 5 ☐ Other (Specify)	Removal from State		le Park	1	17/09 R	iverdale	, MD
alti	permit. Page Department of Important: If any Injury or once.		21. Signature of Funeral Service Licens	see	22	. Name and Addre	ss of Facility L			Home, Inc.
	80 E # 9		P (0)	cc0278						n,DC 20011 Approximate
		65 A	23a. Part 1. Enter the disease, or comp shock, or heart failure. List only o Immediate Cause (Final	ne cause on each line.	ī		ng, such as cardiac	or respiratory arre	:51,	Interval Between Onset and Death
	Physician / /Medical		disease or condition resulting in death)	a. Novic		ction				-
	Examiner			b						
0	e e e e e e e e e e e e e e e e e e e	iner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events	Due to (or as a consequ	uence of):					
D	xecute and Il-trans	Examiner	that initiated events resulting in death) Last	c Due to (or as a consequ	uence of):					
68760,	icate be executed physician and the burial-transit	Sal		d .						
89	# © Se	Medical	IE ECHALC:			- 02			1 82	
Вох	eath cer attendin for use	Physician/	IF FEMALE: 23b. Was decedent pregnant in the past 12 months?	23c. If yes, outcome of pregna 1 ☐ Live birth 2 ☐ Feta	Ideath 3	Ectopic pregnanc	су		23d. Date of de Month	elivery Day Year
0	at the dea	ysic	1 ☐ Yes 2 ☐ No 9 ☐ Unknown	4 ☐ Pregnant at time of d 9 ☐ Unknown	death 5L	Other (specify) _				
σ,	that the		Part II. Other significant conditions co	ntributing to death but not res	ulting in the u	nderlying cause giv	en in Part I.	23e. Did tob	pacco use contribute t	to the cause of death?
Records,	w requires s been sign should be	ed by						1 □ Ye	s 200 No 3 P	Probably 4 Unknown
မင္ပ	law re as be 2 sho	Completed						24a. Was ar	24b. Were a	autopsy findings available completion of cause of
<u>E</u>	ian: The law rtificate has stor, page 2 s	Con						perform 1 □ Yes 2	No 1 □Ye	
Vital	sician: certific	Be	25. Was case referred to medical examiner?	Hospital: 1 K Inpatient 2 □	ED/Outpotion	Ott	or.	th (Check only one		anifu)
	ding Phys n. After this funeral di	n: To	1 Yes 2 No 27. Manner of Death	28a. Date of Injury (Month, Day, Year)	28b. Time o	IL S LI DOM	4 Li Nuising n		ence 6 Other (Sp. ow injury occurred	ecny)
ion		atio	Natural 5 Pending investigation		injury		Yes 2□No			
Division	I or Attendater death Director:	Certification:	3 ☐ Suicide 6 ☐ Could not be 4 ☐ Homicide determined	28e. Place of Injury - At ho building, etc. (Specif	ome, farm, str fy)	eet, factory, office		28f. Location (St. City or Town	reet and Number or F n, State)	lural Route Number,
	spital ours a neral [29a. Certifier 1 Certifying Phy	ysician: To the best of my kno	owledge, deat	h occurred at the t	ime, date and place	e, and due to the c	ause(s) and manner	as stated.
	To the Hospital or within 24 hours after To the Funeral Direction completely filled in b	Medical	(Check only 2 Medical Examone)	liner: On the basis of examina and manner stated.	ation and/or in	vestigation, in my	opinion, death occu	rred at the time, d	ate and place, and du	e to the cause(s)
_	Vithi Com	Ž	29b. Signature and title of certifier	4		29c. Licen:			9d. Date signed (Mor	
	50		> Highelle	lèc		KES	- 000		recember 10	21287 Utimore MD
			30. Name and address of person who o	ompleted cause of death (Item	n 23a) (Type, e (fon	60	0 N.	Wolfe	St. Ra	etimore MD
	Sta	ite	31. Date filed (Month, Day, Year)	Leckal (ature	1.1			- 1200	
	Registr	ar	nfc 18 2009	Deneur B.	gar	-				

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Day Andrea Kunen Barr Month **Physician** 9, 11:09AM December 2009 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Montgomery General Hospital 01ney Montgomery If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) Social Security Number 6. Sex 7. Age (In yrs. last birthday, **Funeral** Hours Min. Months Days 1 □ M 2 🕅 F Director 63 March 25,1946 579-64-7593 New York Usual Residence of Decedent 10d. Inside City Limits 10b. County 10c. City, Town or Location 10a. State 23a or 28a-f show ir than "natural", or items 23a or 28a-f show the Medical Ever Instrument be notified at Director 1 Tyes 2 □ No MD Montgomery Brookeville 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code with 2 High Street 20833 United States death v Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black White etc. within 72 hours after 1 ☐ Never Married 2 ☐ Married Maryland 21215-0036 1 □Yes 2X No Specify ģ Specify: 3 Nidowed 4 Divorced White Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry College (1-4or 5+) Elementary/Secondary (0-12) Realtor Real Estate permit. Pages 1 and 2 should be filed v Department of Health and Mental Hygis Important: If item 27 is marked other any Injury or other traumatic event, II 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be James Kunen Marcia Robison ပ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Joshua Barr / son 1118 Edmonston Drive, Rockville, MD 20851 Baltimore, 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 Burial 2 Cremation 3 E Removal from State National Crematory Falls Church, VA 12/12/2009 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility
Edward Sagel Funeral Direction, Inc.

Edward Sagel Funeral Direction, Inc. 21. Signature of Funeral Service Licensee Jamie Arthurs 1091 Rockville Pike, Rockville, MD M01163 Approximate Interval Between Onset and Death 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) **Physician** Acute Myocardial Infarction Immed. /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examine burial-tran Due to (or as a consequence of) attending physician for use as the buria certificate be Physician/Medical IF FEMALE 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months? 3 Ectopic pregnancy Month Day Year Pregnant at time of death 5 Other (specify) ☐Yes 2 XNo P.0. 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Division of Vital Records, ģ 1

▼ Yes 2 No 3 Probably 4 Unknown Completed Hyperlipidemia 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? 24 No 1 TYes Hospital or Attending Physician: 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 Yes 2 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3X DOA မ After this completely filled in by the funeral 28a. Date of Injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: 5 Pending investigation 1 🔀 Natural 1 ☐ Yes 2 ☐ No death. 2 Accident 24 hours after death e Funeral Director: 6 ☐ Could not be 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide 29a. Certifier to the cause (s) and manner as stated Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. To the I within 2 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 29c. License number 12890 December 18, 2009 address of person who completed cause of death (Item 23a) (Type, Print)
M. Wiseman, MD 5410 Connecticut Ave, NW Washington, DC 20015

State

Registrar

31. Date filed (Month, Day, Year)

DEC 18

parked

32. Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death Day Evelyn Blizzard Dec 19 2009 4c. County of Death 4b. City, Town, or Location of Death

for State Registrar 1. Decedent's Name (First, Middle, Last) 16:20 **Physician** Joanne /Medical 4a. Facility Name (If not institution, give street and number) **Examiner** Calvert Memorial Hospital Prince Frederick Calvert Birthplace (State or Foreign Country) If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** Hours Days 1 □ M 2 👽 F 79 015 24 1732 Jan 29, 1930 Boston, Mass Director Usual Residence of Decedent 10d. Inside City Limits 72 hours after death with the Maryland 10a. State 10c. City, Town or Location 10b. County item 27 is marked other than "natural", or items 23a or 28a-f show other traumatic event, the Modical Examinar must be notified at Calvert Dunkirk 1 □Yes 2**X**(No Director 10f. Zip Code 10g, Citizen of What Country? 10e. Street and Number United States 20754 11226 Lakeview Drive Funeral 14. Race - American Indian, Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 11. Marital Status Black, White, etc. 1 □Yes 2 ☑ No If Yes, Give X Year or Dates: 1 ☐ Never Married 2 Married Baltimore, Maryland 21215-0036 1 □Yes 2□No Specify Specify: White \$ 3 Widowed 4 Divorced Completed 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) be filed within and Mental Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) Nurse Medical 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be John Taylor Evelyn R. Cole မ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 127 Terra Linda Place, Palm Beach Gardens, Fl Pages 1 and 2: ment of Health a ant: If item 27 is ury or other trai Mark Blizzard (Son) 20c. Location - City or Town, State Date 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition permit. Pages Department o Important: If i any injury or once, 1XXBurial 2 ☐ Cremation 3 ☐ Removal from State Resurrection Cemetery 12/24/2009 | Clinton, Maryland 4 □ Donation 5 □ Other (Specify) 22. Name and Address of Facility Lee Funeral Home, Inc. 6633 Old 21. Signature of Funeral Service Licensee 101222 Alexandria Ferry Road, Clinton, MD 20735 Approximate Interval Between Onset and Death 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final a. Multiple Myelor

Due to (r as a consequence of). UCLS Physician disease or condition resulting in death) /Medical Examiner Sequentially list conditions, if any, leading to immediate cause. Emer Unidentying Cause (Disease or injury that initiated events Due to (or as a consequence of) Examine law requires that the death certificate be executed attending physician and for use as the burial-tran resulting in death) Last Due to (or as a consequence of): Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy in the past 12 months?
1 ☐ Yes 2 🛣 No Month Year 4 Pregnant at time of death 5 Other (specify) P.0. been signed by the should be detached 9 Unknown 9 Unknown þ 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Division of Vital Records, Completed by Nellites 2 No 3 ☐ Probably 4 ☐ Unknown 1 ☐ Yes 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an certificate has S The page performed 1 ☐Yes 2 ☐ No 2 **M**No 1 ☐ Yes or Attending Physician; After this certification, I 25. Was case referred to medical 26. Place of Death (Check only one) Be examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2▼ ER/Outpatient 3 DOA 1∐ Yes 2⊠No 1 Inpatient 27. Mann of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural 5 Pending hours after death.
uneral Director: Af 1 ☐ Yes 2 ☐ No 2 Accident investigation Could not be determined 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 Suicide 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a, Certifier (Check only one) and manner stated. 29d, Date signed (Month, Day, Year)

Medical Certification: To To the Hospital within 24 hours a To the Funeral I completely filled 29c. License number 29b. Signature and title of certifier December 21 2009 D 0026607

30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Suite 704 6188 Oxon Hill Road, Oxon Hill, MD Edward T. Cullen, M.D.

gens.

State Registrar

20745

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 3. Time of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Day 2009 12 28 06:40 Helga Calimer 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 16520 Buck Lantz Rd. Sabillasville Washington Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) 5. Social Security Number 6. Sex Days Hours 1 □ M 2 1 □ F 79 09 23 1930 170-30-3622 Germany Usual Residence of Decedent 10d, Inside City Limits 10c. City, Town or Location 10a. State 10h County 1 ☐ Yes 2 X No MD Wasington Sabillasville 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number 16602 Buck Lantz Rd. 21780 US 14. Race - American Indian, Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 1 ☐ Never Married 2 ☐ Married 1 ☐ Yes 2X No Specify: Specify: white 3 ₩ Widowed 4 □ Divorced 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) shoe factory 12 seamstress 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Liesbeth Hirsh Fritz Sedlag 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a, Informant's Name/Relationship (Type. Print) Sabillasville, MD 21780 16520 Buck Lantz Rd. Pamala C. Fox 200 Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition December 30. 1 Burial 2 □ Cremation 3 □ Removal from State Bethel Church Cemetery Cascade, MD 5 Other (Specify) 4 ☐ Donation 22. Name and Address of Facility Grove-Bowersox Funeral Home, Inc. 21. Signature of Feneral Service License Waynesboro, PA 17268 50 S. Broad St. 23a. Part1. Inter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock/or heart failure. List only one of the one each line. Approximate Interval Between Onset and Death Immediate Cause (Final Per ejuc mous disease or condition resulting in death) Due to (or as a consequence of):

Physician /Medical Examiner

Physician

/Medical

Examiner

Funeral

Director

ral", or items 23a or 28a-f show Eventions and be notified at

"natural",

permit. Pages 1 and 2 should be filed within 72 ho Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "natur any injury or other traumatic event, the Medical Once.

Director

Completed by Funeral

Be

၉

Pages 1 and 2 should be filed within 72 hours after death with the Maryland

Baltimore, Maryland 21215-0036

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Division of Vital Records, P.O. Box 68760.

Completed by Physician/Medical Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	b		
/sician/Me	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ TNo 9 □ Unknown	23d. Date of delivery Month Day Year		
ed by Phy		contributing to death but not resulting in the underlying by Literature Dul	ig dadde giver in rair ii	oid tobacco use contribute to the cause of death?
complete		direct	24a. V a 1 DYe	utopsy prior to completion of cause of death?
	25. Was case referred to medical		26. Place of Death (Check or	aly one) deughtes
To Be	examiner? 1 ☐ Yes 2 ☐ No	Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐	DOA Other: 4 Nursing Home 5 F	Residence 6 Other (Specify) Hone
ation: T	27. Manner of Death 1 □ Matural 5 □ Pending 2 □ Accident investigation	28a. Date of Injury (Month, Day, Year) 28b. Time of Injury M	28c. Injury at Work? 1 Yes 2 No	be how injury occurred
Certification:	3 Suicide 6 Could not learnined		etory, office 28f. Location City or	on (Street and Number or Rural Route Number, Town, State)
Medical (29a. Certifier 1 Certifying P (Check only 2 Medical Exa	Physician: Fo the best of my knowledge, death occuminer: On the basis of examination and/or investigated and manner stated.	rred at the time, date and place, and due to ation, in my opinion, death occurred at the ti	me, date and place, and due to the cause(s)
Me	29h Signature and title of certifier		29c. License number	29d. Date signed (Month, Day, Year)

123623

State

11.11

address of person who completed dause of death (Item 23a) (Type, Print)

(Month, Day, Year)

TI MY

32. Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

AMEND TTEM#31 per DVR, G899, 17,7/2010, WS
State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician Month PAUL ANDREW CROWL 19 2009 5:15 December p /Medical 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death Examiner 4c. County of Death Greater Baltimore Medical Center Towson Baltimore 9. Birthplace (State or Foreign Country) Maryland 5. Social Security Number 6. Sex If Under 24 Hrs. 8. Date of Birth (Mgnth, Day, Year) 9/5/1927 7. Age (In vrs. last birthday) **Funeral X**□ M 2 □ F Months Days Hours Min 219-36-0402 82 Director Usual Residence of Decedent 10b. County 10c. City, Town or Location 10a. State an "natural", or items 23a or 28a-f show Medical Examiner must be notified at 10d. Inside City Limits Director 1 ☐Yes 2♥ No MD Harford Street 10e. Street and Number 10f, Zip Code 10g. Citizen of What Country? 21154 USA 101 Cherry Hill Road Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc 1 Never Married 2 Married White 1 □Yes X□No Specify: \$ Pages 1 and 2 should be filed within 72 hours or nent of Health and Mental Hygiene. 3 ☐ Widowed 4 ☐ Divorced Be Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) College (1-4or 5+) Elementary/Secondary (0-12) Farmer Agriculture is marked other Maryland 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Carroll W. Crowl Mary Irene Butler ပ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Department of Health a Important: If item 27 is any Injury or other tra once. Mary Elizabeth Crowl/Wife 101 Cherry Hill Road, Street, MD 21154 Baltimore, 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1X Burial 2 ☐ Cremation 3 Removal from State 12/23/09 Street, MD 4 ☐ Donation 5 ☐ Other (Specify) Highland Cem. 21. Signature of Fune 22. Name and Address of Facility 600 Main St. Delta, PA 17314 Inc.Delta, Harkins Funeral Home, C. Kover 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** disease or condition resulting in death) wann /Medical Due to (or as a col Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Physician/Medical Examiner To the Hospital or Attending Physician: The law requires that the death certificate be execute within 24 hours after death. After this reatificate has been been executed to the Funeral Director: After this reatificate has been been executed. Division of Vital Records, P.O. Box 68760. burial-tran Due to (or as a consequence of) attending physician for use as the buria as the IF FEMALE: 23c. If yes, outcome of pregnancy 23b. Was decedent pregnant 23d. Date of delivery 1 ☐ Live birth 2 ☐ Fetal death 4 ☐ Pregnant at time of death 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) in the past 12 months? 1 ☐ Yes 2 ☐ No Month Year signed by the a 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ð 1 ☐ Yes 2 ☑ No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an 2 **1** No 1 □Yes t □Yes 2 □ No filled in by the funeral director. 25. Was case referred medica examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 **1** No 1 Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To 27. Manner of Death Date of Injury (Month, Day, Year) 28b. Time of 28d. Describe how injury occurred 28c. Injury at Work? 1 V Natural
2 Accider 5 Pending investigation Injury 1 ☐ Yes 2 ☐ No Accident 3 Suicide 6 Could not be determined 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide Medical 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. ompletely 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 30. Name and address of person who completed cause of death (Item 23a) (Type, 0 31. Date filed (Month, Day, 32. Registrar's Signature State Registrar

	Phy /N Exa	/s le
O. Box 68760,	the death certificate be executed	Coo deicionada paipaesto esta
Division of Vital Records, P.O. Box 68760,	dospital or Attending Physician: The law requires that the death certificate be executed	+ nours arien dearm.
	losp	00 +

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Day 11:15 AM **Physician** DECEMBER 23. FLORA BELLE CASSELL 2009 /Medical 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) Examiner CHARLES LA PLATA MEDICAL CENTER CIVISTA 8. Date of Birth (Month, Day, Year) 3 – 25 – 1918 If Under 1 Year | If Under 24 Hrs. 9. Birthplace (State or Foreign 5. Social Security Number 7. Age (In yrs. last birthday Funeral Days Hours Country) 1 □ M 2 👽 F TENN 91 218-88-9055 Director Usual Residence of Decedent 10d. Inside City Limits 10h. County 10c. City, Town or Location 10a. State 28a-f show permit. Pages 1 and 2 should be filled within 72 hours after death with the Maryla Department of Heath and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-1 show any injury or other traumatic event, the Medical Examination and by Indillad at 1 ☐Yes 2 ☐No Director MD. CHARLES WALDORF 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number 20602 U.S.A. 913 WADDELL ROAD Funeral Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. 12. Was Decedent Ever in U.S. Armed Forces? 11. Marital Status Black, White, etc. 1 □Yes 2 □ No If Yes, GiveX Year or Dates: 1 ☐ Never Married 2 ☐ Married SpecifyWHITE 1 □Yes 2 ₩ No Specify: þ 3 Widowed 4 ☐ Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a Decedent's Usual Occupation 16h. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) College (1-4or 5+) Elementary/Secondary (0-12) OWN HOME HOMEMAKER 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be NANCY PERKY JOHN RUSH 2 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 913 WADDELL RD. WALDORF, MD. 20602 BARBARA GONZALEZ-DAUGHTER 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition 1 Burial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify) TRINITY MEM.GARDENS 12-30-09 WALDORF, MD 22. Name and Address of Facility M00479RAYMOND FUNERAL SERVICE, P.A. LA PLATA, MARYLAND 20646 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause of each line. Approximate nterval Between Onset and Death Immediate Cause (Final ician disease or condition resulting in death) dical Due to (or as a nsequency of): niner nermonia Sequentially list conditions, it any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examine burial-transit Dementia Due to (or as a consequence of): Physician/Medical ig pnysi as the t IF FEMALE: nse 23c. If yes, outcome of pregnancy

1 Live birth 2 Fetal death
4 Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 - Ectopic pregnancy Month Day Year for in the past 12 months? 5 ☐ Other (specify) ☐Yes 2 ☐No cate has been signed by the page 2 should be detached 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. \$ 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed 1 ☐Yes 2 ☐ No 1 □Yes 2 □No 25. Was case referred to medical examiner? 26. Place of Death (Check only one) director, Be Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 1 Yes 2 No Certification: To 28a. Date of Injury (Month, Day, Year) 28b. Time of 28d. Describe how injury occurred 27. Manner of Death 28c. Injury at Work? 1 Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) à à 4 Homicide filled in 1/ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical (Check only one) and manner stated. within 2 To the f 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of vertilier D0057999 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) TERRACE DRIVE SUITE 103, WALDORF, MD 20603 MANISHA J. JARIWALA. 11637 M.D. ite filed (Month, Day, Year JAN 0 7 2010 32. Registra 's Sig

Registrar DHMH 17 Rev 1/2001 Physician

/Medical

Examiner

1 - For State Registrar

1. Decedent's Name (First, Middle, Last)

AVID

230-50-0230

Maryland

20244 Aquasco Road

20244 Aquasco Road

15. Decedent's Education (Specify only highest grade completed)

1 Never Married 2 Married

3 ☐ Widowed 4 ☐ Divorced

Elementary/Secondary (0-12) 12

17. Father's Name (First, Middle, Last)

1 X Burial 2 ☐ Cremation

21. Signature di Funeral Service Licensee

4 Donation

James A. Crance

19a. Informant's Name/Relationship (Type. Print)

Hallie J. Crance/Wife

5 ☐ Other (Specify)

4a. Facility Name (If not institution, give street and number)

1**Д** М 2□ F

Prince Frederick

Physicia ∴/Medica		23a. Part 1. Enter the disease, or compl shock, or heart failure. List only of Immediate Cause (Final disease or condition resulting in death)	ications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, ne cause on each line. a. Due to (or as a consequence of):	Approximate Interval Between Onset and Death
ificate be executed ificate be executed physician and is the burial-transit	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	Due to (or as a consequence of): Due to (or as a consequence of): Due to (or as a consequence of):	
UNISION OF THE HOSPITAL OF Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit	Physician/Medical	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	23c. If yes, outcome of pregnancy 1	livery Day Year
aw requires that the second of	þ	Part II. Other significant conditions co	ntributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to 1 Yes 2 No 3 P 24a. Was an 24b. Were at	robably 4 Unknow
VII.dl net ician: The lav certificate has ector, page 2	Be Completed	25. Was case referred to medical examiner?	performed? death? 1	utopsy findings available completion of cause of s 2 □ No
stori or tending Phys leath. tor: After this the funeral dir	ation: To	27. Manner of Death Natural 5 Pending 2 Accident investigation	28a. Date of Injury (Month, Day, Year) 28b. Time of Injury M 28c. Injury at Work? 1 Yes 2 No 28d. Describe how injury occurred	
DIVIX pital or Att urs after de eral Direct illed in by t	Certification:	3 Suicide 6 Could not be determined	28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or R. City or Town, State)	
the Hosp nin 24 ho the Fune	Medical	(Check only 2 Medical Exam one)	rsician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner a finer: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and durand manner stated.	e to the cause(s)
Ostra, Os	Δ	29b. Signature and dittle of certifier 30. Name and address of person who c	29c. License number 29d. Date signed (Monte of Defense Huy Annapole of Defense	100
? Regi	tate strar	31. Date filed (Month, Day, Year)	32. Registrar's Signature 009 Sum & Same	
DHMH 17 Rev	1/2001		ORIGINAL	

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

RANCE

10c. City, Town or Location

Aquasco

Trooper

20b. Place of Disposition (Name of cemetery, crematory or other place)

St. Mary's Episcopal Gem.

7. Age (In yrs. last birthday)

68

M00817

College (1-4or 5+)

Certificate of Death

Aquasco

Months

10f. Zip Code

1 ☐ Yes 2 X No

16a. Decedent's Usual Occupation

20608

Days

State of Maryland / Department of Health and Mental Hygiene 2009

4b. City, Town, or Location of Death

If Under 1 Year | If Under 24 Hrs.

Hours

13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

Specify:

(Give kind of work done during most of working life. DO NOT use retired)

2. Date of Death

8. Date of Birth (Month, Day, Y June 13,

18. Mother's Name (First, Middle, Maiden Surname)

12/23/2009

22. Name and Address of Facility Brinsfield—Echols F.H., P.A.,

Ettie Lee Carper

Date

PO Box 128, Charlotte Hall, MD 20622

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

20244 Aquasco Road, Aquasco, MD 20608

Month

3. Time of Death

9. Birthplace (State or Foreign Country) Virginia

10d. Inside City Limits

1 ☐ Yes 2 No

09

Prince George's

4c. County of Death

10g. Citizen of What Country?

United States

Black, White, etc.

Specify: White

Aquasco, MD

Approximate

16b. Kind of Business/Industry

State Police

Maryland

1941

0325M

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death EDWARD CULLISON Physician/ Month CLAYTON 2009 10:45 a.M. December Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death Examiner 4c. County of Death St. Mary's 44500 Hawks Nest Farm Lane Leonardtown Social Security Numbe 6. Sex 1 X M 2 ☐ F 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth g. Birthplace (State or Foreign **Funeral** Months Days Hours Min. 02/19/1943 Mary Land Director 215-38-3439 66 Usual Residence of Decedent or 28a-f shov notified at 10a. State 10b. County 10c. City, Town or Location the Maryland 10d. Inside City Limits Director 1 Yes 2 X No Maryland St. Mary's Leonardtown 10e, Street and Number ō 10f. Zip Code 10g. Citizen of What Country? must be 23a Funeral 20650 United States 44500 Hawks Nest Farm Lane items ? permit. Page 1 and 2 should be filed within 72 hours after death Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14. Race - American Indian, Examiner rmed Forces?

Yes 2 X No Black, White, etc. ō þ 1 Never Married 2 X Married Baltimore, Maryland 21215-0036 If Yes, Give Year or Dates 1 Yes 2 X No Specify: "natural", 3 Widowed 4 Divorced Completed White th and Mental Hygiene. 27 is marked other than "natu traumatic event, the Medical 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) 12 Excavation Contractor Excavation Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ည Paul Edward Cullison Mary Wood 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Department of Health a Important: If item 27 is any injury or other trau once. P.O. Barbara H. Cullison/Wife Box 65, Valley Lee, MD 20692 20a. Method of Disposition
1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 20b. Place of Disposition (Name of 20c. Location - City or Town, State cemetery, crematory or other place) 4 Donation 5 Other (Specify) Brinsfield-Echols Cre:12/19/2009 Charlotte Hall, MD 22. Name and Address of Facility Brinsfield Funeral Home, P.A. gnatur of Funeral Service Libersee

Baward N. Brinsfield M00052 22955 Hollywood Road, Leonardtown, MD 20650 23a. Part 1. Enter the disease, or complications the caused the death, shock, or heart failure. List only one cause on ach line. Onset and Death Immediate Cause (Final Physician/ disease or condition Medical resulting in death) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury that initiated events Due to (or as a consequence of) Exami -transit Hospital or Attending Physician: The law requires that the death certificate be executed Due to (or as a consequence of): resulting in death) Last physician a Physician/Medical Box 68760 as attending IF FEMALE: use 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy for in the past 12 months? 4 Pregnant Pregnant at time of death 5 Other (specify) signed by the a Yes 2 No g Unknown Division of Vital Records, P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 2 No 3 Probably 4 Unknown page 2 should Were autopsy findings available prior to completion of cause of 24a, Was an nas autopsy performed? Yes 2 No death? certificate 1 Yes 2 No director, Be 25. Was case referred to medical 26. Place of Death (Check only one) Hospital 2 2 00 1 Tyes မ 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify, nin 24 hours after death.

the Funeral Director: After this on the funeral director is the funeral director. 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of Certificate: 28c. Injury at 28d, Describe how injury occurred injury work? 1 ☐ Yes 5 Pending Accident
Suicide 2 🗌 No Investigation 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined City or Town, State) Medical ed fying Physicia at: 1, the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Medi al Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier

within 2

To the I Occasion pme

Terence R. Bertele Date filed (Month, Day, Year, State Registrar

(Check

32. Registrar's Signature

of my knowledge, de

Gertifying Nurse Fractionen To the bast

30. Name , and are ss of person who completed cause of death (Item 23a) (Type, Print)

M. D

DHMH 17 Rev 7/2009

29c. License number D 3004

23511 Hollywood Road, Leonardtown,

29d. Date signed (*Month, Day, Year*)

MD

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death December 18, 2009 1816 C. Courtney Agnes 4c. County of Death 4a, Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death St. Mary's St. Mary's Hospital Leonardtown If Under 1 Year | If Under 24 Hrs. Months Days Hours Min. 9. Birthplace (State or Foreign Country) Maryland 8. Date of Birth (Month, Day, Year) 5/01/1950 5. Social Security Number 6. Sex 7. Age (In vrs. last birthday Days 1 M 200 59 218-76-5075 Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10b. County 1 ☐ Yes 2XXXNo Maryland St. Mary's Hollywood 10g. Citizen of What Country? 10f, Zip Code 10e. Street and Number USA 20636 41900 Stephen Young Court 14. Race - American Indian, Black, White, etc. 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 1 ∐Yes 2 1 No If Yes, Give Year or Dates: 1 Never Married 2 X Married 1 ∐Yes 2 ⊠No Specify. Black. Specify: 3 ☐ Widowed 4 ☐ Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) Housekeeper Hospital 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) C. Ho1t Carrie E., Mason John 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) Herbert L. Courtney/Spouse P.O. box 923, Leonardtown, MD 20650 20c. Location - City or Town, State 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State 12/28/2009 4 ☐ Donation 5 ☐ Other (Specify) Charles Memorial Leonardtown, MD 21. Signature of Funeral Service Liminsee Edward N. Brinsfield, Jr. M00052 22. Name and Address of Facility Brinsfield Funeral Home, P.A. 22955 Hollywood Rd., Leonardtown, MD 20650 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) ventricular standatill minutes Due to (or as a consequence of): hypoxia respiratory arreit Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to for as a consequence of Due to (or as a consequence of): IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Day in the past 12 months? 1 ☐ Yes 2 No Month Year 4 Pregnant at time of death 5 Other (specify) 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 😿 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? 1 ☐ Yes 2 No 1 ☐ Yes 2 ☐ No 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 1 ☐ Yes 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural 2 ☐ Accident 5 Pending investigation 1 ☐ Yes 2 ☐ No

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29d. Date signed (Month, Day, Year)

DUT | NEY AGINES Division of Vital Records, P.O. Box 68760,

burial-tran **To the Funeral Director:** After this certificate has been signed by the attending physician completely filled in by the funeral director, page 2 should be detached for use as the buria Hospital or Attending F 24 hours after death. Funeral Director: After

Physician

/Medical

Examiner

10a State

Director

Funeral

Completed

Be

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Examiner

Physician/Medical

Completed

Be

Certification: To

Medical

3 Suicide

29a. Certifier

4 Homicide

(Check only one)

29b. Signature and title of certifier

Funeral

Director

permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Macical Examined must be notified at once.

Physician

/Medical

Examiner

Baltimore, Maryland 21215-0036

To the within 2 4 copies pine

State Registrar

DHMH 17 Rev 1/2001

31. Date filed (Month, Day, Year)

30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 2500 Pt Lookout Rd St Mary's Fill Leaner thoun Mis 20650 MA 27.0

and manner stated.

6 ☐ Could not be

32. Registrar's Signature

Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

ORIGINAL

1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)

29c. License number

100 68546

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Year 30 PM JUSE 4c. County of Death 4a. Facility Name (If not institution, give street and number) Town, or Location of Death niversit ltimo 8. Date of Birth (Month, Day, Year) December 25,1963 Birthplace (State or Foreign Country) If Under 1 Year | If Under 24 Hrs. 5. Social Security Number . Age (In yrs. la Months Days Hours Min. 1 XM 2 □ F 46 Yrs. Maryland 215-80-4512 Usual Residence of Decedent 10d. Inside City Limits 10b, County 10c. City, Town or Location St. Mary's 1 ☐ Yes 2X No Maryland Lexington Park 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number 20653 USA 21086 Hermanville Road 12. Was Decedent Ever in U.S. Armed Forces? 1 □Yes 2 🕱 No 14. Race - American Indian, Black, White, etc. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 □Yes 2 🔀 If Yes, Give Year or Dates: 1 Never Married 2 ☐ Married Black 1 ☐ Yes 2 🛛 No Specify: Specify 3 ☐ Widowed 4 ☐ Divorced 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Disabled 10 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last)

Mary Patricia Fenwick

Physician /Medical Examiner

1 - For State Registrar

10a State

Director

Funeral

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Completed

Be

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James Francis Clinton

Physician

/Medical

Examiner

Funeral

Director

item 27 is marked other than "natural", or items 23a or 28a-f show other traumatic event, the Wolfort Event and the collised at

72 hours after death with the

filed within 7 I Hygiene.

permit. Pages 1 and 2 should be filed within Department of Health and Mental Hygiene. Important: If item 27 is marked other than any injury or other traumatic event, Ita M.

Saltimore, Maryland 21215-0036

and burial-1 physician the attending pl the been signed by the should be detach has

Box 68760,

P.0.

Division of Vital Records,

law requires that the death certificate be executed page 2 should certificate director. within 24 hours after death.

To the Funeral Director: After this funeral Hospital or Attending the

completely end

filled in by

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 21086 Hermanville Road Lexington Park, MD 20653 M. Patricia Miles / Mother 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20a. Method of Disposition January 2. 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State St. James Catholic Cemetery Lexington Park, Maryland 4 ☐ Donation 5 ☐ Other (Specify) 2010 22. Name and Address of Facility Mattingley-Gardiner Funeral Home, P. P.O. Box 270 Leonardtown, MD 20650 P.A. Part L. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Due to (r as a consequence of): disease or condition resulting in death) espiratory Sequentially list conditions Examiner as a consequence of cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Year in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Pregnant at time of death 5 ☐ Other (specify) 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ş 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy perform 2 No 1 ☐Yes 2 ☐ No 1 □Yes 26. Place of Death (Check only e) 25. Was case referred to medical examiner? Be Hospital Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 ☑ No 2 ER/Outpatient 3 DOA Inpatient Certification: To 27. Manner of Death Date of Injury (Month, Day, Year) 28b. Time of Injury 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No Accident 6 Could not be determined 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a, Certifier Medical (Check only one) and manner stated. 29d. Date signed (Month, Day, Year) 29c, License number 29b. Signature and title of certifier 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 32. Registrar's Signature State Registrar ORIGINAL

DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene 2009

			1 State Registrar		,	Certif	icate of l	Death	Reg	g. No.	
	Physicia	an	1. Decedent's Name (First, Middle, Las	•					2. Date of Death Month	Day Year	3. Time of Death
	Physicia /Medic		Janie Cecelia E		tis				December		
	Examin	er	4a. Facility Name (If not institution, give 29138 New Marke		Road	1		Location of Death		4c. County of Dea	
	Funeral		5. Social Security Number 6. S		(In yrs. last birt		Under 1 Year onths Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day,	(ear) 9. Bi	rthplace (State or Foreign
ŀ	Director		219-16-1009 Usual Residence of Decedent	□ M 2 🖾 F	97	Yrs.	Days	Tiodis Will.	12/01/19	12	Maryland
	/land		10a. State 10b. County		10c. City, Town	or Location	on				10d. Inside City Limits
	a-f sh	ctor	Maryland St. Ma	ary's	Cha	arlot	te Hall	L			1 □Yes 2 🗓 No
	or 28	Director	10e. Street and Number			1	0f. Zip Code		109	g. Citizen of What C	
	sath w	Funeral	29138 New Market	t Village 12. Was Decedent E		12 Was		0622	pacify Vas or No-	U S A	
Ω	riter		11. Marital Status 1 ☐ Never Married 2 ☐ Married	Armed Forces? 1 ∐Yes 2★ N				ispanic Origin? (Sp an, Mexican, Puerto	Rican, etc.)	Black, Wh	
Maryland 21215-0036	be filed within 72 hours after death with the Maryland ntal Hygiene. ed other than "natural", or items 23a or 28a-f show event, the Medical Event har rougher portified as	d by	3 ☑ Widowed 4 ☐ Divorced	If Yes, Give Year or Dates:		1	Yes 2ygytNo	Specify:		Specify:	Black
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Baltimore,	permit. Page Department Important; I any Injury o		21. Signature of Funeral Service Licen	and I	M0019	22. Na Br 30.	me and Addresinsfiel 195 Thr	s of Facility d-Echols ee Notch	Funeral Rd., Cha	Home, P.A rlotte Ha	11, MD 20622
			23a. Part1. Enter the disease, or composition of the street failure. List only	olications that caused one cause on each lin	the death. Do n						Approximate Interval Between
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	/Medical Examiner		resulting in death)	Due to (or as a	a consequence o	of):					
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O. B	the death by the atten sched for u	Physician	in the past 12 months? 1 □ Yes 2 No 9 □ Unknown	4 Pregnant at			ner (specify)	у		Month	Day Year
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	The ate h page	Completed							perform	ed? death′	
Vital	Attending Physician: The or death. ector: After this certificate by the funeral director, pag	Be	25. Was case referred to medical examiner?	Hospital:			DOA Oth	or:	h (Check only one		
Ö	g Physer this eral di	n: To	1 ☐ Yes 2 No 27. Manner of Death	28a. Date of Injur		ime of	28c. Injur Work	4 LI Nuising no	ome 5 Resider 28d. Describe hov	nce 6 Other (Sp v injury occurred	pecify)
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Division	or Atter de after de Directo	Certification:	3 ☐ Suicide 6 ☐ Could not be 4 ☐ Homicide determined	28e. Place of Inju building, etc	ry - At home, far . <i>(Specify)</i>	rm, street,	factory, office		28f. Location (Stre City or Town,		Rural Route Number,
	To the Hospital or Attendi within 24 hours after death. To the Funeral Director: A completely filled in by the fu	edical C	29a. Certifier (Check only one) Certifying Ph	ysician: To the best on the best of the basis of and manner sta	examination and	e, death oc d/or investi	curred at the tii	me, date and place ppinion, death occur	, and due to the ca rred at the time, da	use(s) and manner te and place, and d	as stated. ue to the cause(s)
	To the within To the comple	Me	29b. Signature and title of certifier				29c. Licens	e number	29	d. Date signed (Mo	nth, Day, Year)
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A	9 h.		30. Name and address of person who of P Wisotsky, M.D.	completed cause of de				Waldorf	, MD 2060	2	
	Sta	te_	31. Date filed (Month, Day, Year)		r's Signature				, 112 2000		
	Registr		DEC 20'	anna 🎉		ho	. W.				

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death I. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Day Lillian M. Cowan 10:00 PM December 2009 Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death St. Mary's Nursing Center <u>Leonardtown</u> Mary's ocial Security Number . Age (In yrs, last birthday) If Under 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** Country) Missouri 1 □ M 2 🏋 F Months Days Hours Min. 09/19/1909 **Director** 498-12-0766 100 Usual Residence of Decedent 10b. County Page 1 and 2 should be filed within 72 hours after death with the Maryland ment of Health and Mental Hygiene. ant: If item 27 is marked other than "natural", or items 23a or 28a-f sho 10c. City, Town or Location 10d. Inside City Limits items 23a or 28a-f sho ner must be notified at Directo 1 Yes 2 X No St. Mary's Leonardtown Maryland 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 40820 Breton Beach Road 20650 USA 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Armed Forces?

1 Yes 2 No Black, White, etc. δ 1 Never Married 2 Married Exami altimore, Maryland 21215-0036 If Yes, Give 1 ☐ Yes 2X No Specify: Specify. 3 X Widowed 4 □ Divorced Completed White Year or Dates the Medical 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) Ith and Mental Hygiene.
27 is marked other than "I rraumatic event, the Med Elementary/Seconday (0-12) College (1-4 or 5+) Department Store Sales Person Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ٩ O'Loglin Μ. Bert т. Kidd Mary 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Elizabeth C. Fenwick/Daughter 40820 Breton Beach Road, Leonardtown, MD 20650 item 2 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State Department of Independent of Independent In Its any injury or of 1 ☐ Burial 2 🖾 Cremation 3 ☐ Removal from State 4 Donation 5 Other (Specify) 12/24/2009 Charlotte Hall, MD <u>Brinsfield-Echols</u> 21. Signature of Funeral Service Clenses Edward N. Brinsfield, Jr., M00052 22. Name and Address of Facility Brinsfield Funeral Home, P.A. 22955 Hollywood Rd., Leonardtown, MD 20650 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardia, or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Approximate Immediate Cause (Final Pnysician/ disease or condition resulting in death) Medical Due to ar as a consequence Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying r as a col attending physician and for use as the burial-transit Exam Hospital or Attending Physician: The law requires that the death certificate be executed Cause (Disease or linjury that initiated events Due to (or as a resulting in death) Last Be Completed by Physician/Medical P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ____ in the past 12 months?
1 ☐ Yes 2 ♠ No 4 Pregnant : 9 Unknown Pregnant at time of death Month Day Year s been signed by the should be detached 9 Unknown Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, 1 ☐ Yes 2 TNo 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a, Was an this certificate has ral director, page 2 autopsy performed' 2 No Yes 2 No 1 Yes funeral director. 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Other: 4 Residence 6 Other (Specify) မ 2 🔯 No 1 Inpatient 2 ER/Outpatient 3 DOA A Hospina.

24 hours after deam.

A Funeral Director: After the funeral in by the funeral Certificate: 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 Natural 5 Pending 1 Yes 2 No Accident Investigation Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Medical 29a. Certifier 🔊 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated within 2 To the F only one) 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title 29d. Date signed (Month, Day, Year)

State Registrar

H) emal

30. Name and addr

31. Date filed (Mon

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person who complete

Jarboe

Ρ.

24035 Three Notch Rd., Hollywood, MD 20636

cause of death (Item 23a) (Type, Print)

gistrar's Signature

M.D.

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Day **Physician** М Rachel Calvert December 1.5 2009 1557 /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death Examiner Anne Arundel Medica1 Center Arunde1 Annapolis Anne ATTITIA DOLLLE

If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth
(Month, Day, Birthplace (State or Foreign Country) 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) **Funeral** Year) 1 □ M 200 Months Days Director 213-34-1454 76 March 5 1933 | Maryland Usual Residence of Decedent show 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits ed other than "natural", or items 23a or 28a-f show event, the Wedical Examination by radified at MYes 2 □ No Director Maryland Anne Arundel Annapolis 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 23 C Bens Drive 21403 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 전 No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 11. Marital Status 2 should be filed within 72 hours after or and Mental Hygiene. Is marked other than "natural", or ite 1 XNever Married 2 ☐ Married Baltimore, Maryland 21215-0036 1 ☐ Yes ZZNo Specify: Specify: Black **今** 3 🗆 Widowed 4 🗆 Divorced Completed 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) 0 10th Elk's Lodge 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be es 1 and 2 should be of Health and Ments fitem 27 is marked rother traumatic e ပ Joseph D. Calvert Agnes Brown 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 21401 19a. Informant's Name/Relationship (Type. Print) Josephine Franklin (Daughter) 619 Severn Island Ct. Annapolis, Md. Pages 1 ; 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State permit. Pages Department of Important: If it any injury or c 1 Burial 2 ☐ Cremation 3 ☐ Removal from State Bestgate Mem. Park 12/23/09 Annapolis, Md. 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility 21. Signature of Funeral Service Licensee Reese & Sons Mortuary, West St. Annapolis, Md 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death **Physician** disease or condition resulting in death) YVS /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, it any early control of cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to for as a consequence offiburial-transi and Due to (or as a consequence of): Box 68760 attending physician certificate be Physician/Medical the IF FEMALE: use 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy Ь in the past 12 months?
1 ☐ Yes 2 XNo
9 ☐ Unknown Month Year 4 ☐ Pregnant at time of death 5 ☐ Other (specify) Ö 9 | Unknown ٣. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Records, þ 1 ☐ Yes 2 ☐ No 3 Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an cate has l page 2 s autopsy performe Division of Vital 1 □Yes 2 No 1 Tyes 2 TNo To the Hospital or Attending Physician: within 24 hours after death.

To the Funeral Director: After this certifica completely filled in by the funeral director, p. 25. Was case referred to medical 26. Place of Death (Check only one) Be examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA Medical Certification: To 27. Manper of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural 5 Pending Investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide 29a, Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

State Registrar 29b. Signatura and file of certifier

31. Date filed (Month, Day, Year)

Stravt

Name and address of person who completed cause of death (Item 23a) (Type, Print)

MO 32. Registrar's Signature

E. Selonian

29d. Date signed (Month, Day, Year) 12/16/2009

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ 2009 4,50 D. M Ruth R. Crouch Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death Hebrew Home of Greater Washington Rockville Montgomery Social Security Number 6. Sex 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth Birthplace (State or Foreign Country) Funeral 1 □ M 2 🔀 F Min 06/26/1930 Director 577-36-8538 79 Usual Residence of Decedent or 28a-f shov 10a. State 10b. County Ħ 10c. City, Town or Location 10d. Inside City Limits Director ral", or items 23a or 28a-f s Examiner must be notified 1 Tes 2 No Kensington Montgomery 10e. Street and Number 10g. Citizen of What Country? Funeral 20895 United States 10905 Orleans Way 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 12. Was Decedent Ever in U.S 14 Race - American Indian Armed Forces Black, White, etc. þ 1 Never Married 2 Married than "natural", or ☐ Yes 21215-0036 1 ☐ Yes 2 🙀 No Specify: If Yes. Give White 3 XWidowed 4 ☐ Divorced Completed Year or Dates other traumatic event, the Medical 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) College (1-4 or 5+) Elementary/Seconday (0-12) Administrative Assistant US Navy - Fed. and Mental Hygie is marked other Be Baltimore, Maryland 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) မ permit. Page 1 and 2 should be Department of Health and Ment. Important: If item 27 is marked any injury or other trainment on the contract of Dexter Rivenburgh Charlotte Vedder 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Michael B. Crouch, Jr. - son 2821 Eagles Mere Court Ellicott City, MD 21042 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place 20c. Location - City or Town, State 1 🗆 Burial 2 🔀 Cremation 3 🗆 Removal from State 4 Donation 5 Other (Specify) 12/20/2009 Ardent Crematory Hanover, MD 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Harry H. Witzke's Family F.H.Inc. M00845 4112 Old Columbia Pike Ellicott City, MD 21043 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between shock, or heart failure. List only one cause on each line Immediate Cause (Final disease or condition Onset and Death - Physician/ ardio-respiratory Medical resulting in death) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examine Due to (or as a consequence of) physician and the burial-transit that the death certificate be executed Cause (Disease or iinjury that initiated events Due to (or as a consequence of): resulting in death) Last Physician/Medical attending p for use as t IF FFMALE 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 3 ☐ Ectopic pregnancy 23b. Was decedent pregnant 23d. Date of delivery in the past 12 months?
1 Yes 2 No Month Day Pregnant at time of death 5 Other (specify) 1 Yes 2 9 Unknown been signed by the s 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 Yes 2 No 3 Probably 4 Unknown Records, Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an page 2 s Jas autopsy or Attending Physician: The performed? 1 Yes 25. Was case referred to medical completed filled in by the funeral director, Be 26. Place of Death (Check only one, examiner's 2 1 No 1 🗌 Yes Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Inpatient 2 ER/Outpatient 3 DOA Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at work? s after death. Certificate: 28d. Describe how injury occurred 🗐 Natural 5 Pending Division Accident 1 Yes 2 No Investigation Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide City or Town, State) within 24 hours a To the Funeral D Hospital Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certifie 80055362 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) bermonente 21015an erson ST 31. Date filed (Month De) State 32. Registrar's Signature

DHMH 17 Rev 7/2009

Registrar

Box 68760

P.O.

of Vital

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) **Physician** Month 0scar Calungcagin , Sr. December /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death County of Death Examiner Fort Washing Fort Washir Tav If Under 1 Year | If Under 24 Hrs. 8. Date of Birth Pay, Feb. 15, Social Security Number 6. Sex 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign Country) Philippines **Funeral** Months Year) 1 ፟M 2 □ F Days Hours Min. 575-15-7777 86 Director Usual Residence of Decedent Pages 1 and 2 should be filed within 72 hours after death with the Maryland 10a. State 10c. City, Town or Location 10d. Inside City Limits 28a-f show of Health and Mental Hygiene.
If item 27 is marked other than "natural", or items 23a or 28a-f shov or other traumatic event, the Medical Examinat must be nothind at 1 ☐ Yes 2 No Director Maryland Prince George's Fort Washington 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 13420 Buchanan Drive 20744 USA Funeral 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Black, White, etc. □Yes 2 No 1 ☐ Never Married 2 X Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 🛣 No Specify: Asian-Filipino β Yes. Give Specify 3 ☐ Widowed 4 ☐ Divorced Year or Dates: Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Philippine Government Carpenter 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Generoso Calungcagin , Sr. ပ Marcela 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Modesta Calungcagin - Wife 13420 Buchanan Dr., Ft. Washington, MD 20744 permit. Pages 1 and 3 Department of Health Important: If item 27 any Injury or other tr once. 2010 20c. Location - City or Town, State 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Jan. Pate 1 ☐ Burial 2 ☐ Cremation 3 🖾 Removal from State Penaranda, Philippines 4 ☐ Donation 5 ☐ Other (Specify) Penaranda Memorial Cem. 22. Name and Address of Facility George P. Kalas Funeral Home, P.A. 21. Signature of Funeral Service Licensee 6160 Oxon Hill Rd., Oxon Hill, MD 20745 23a. Part . Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final **Physician** /Medical resulting in death) Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examine Due to for as a consequence of ospital or Attending Physician: The law requires that the death certificate be executed 4 hours after death.

Underal Director: After this certificate has been signed by the attending physician and ng physician and as the burial-transit Due to (or as a consequence of) Division of Vital Records, P.O. Box 68760, Physician/Medical the attending p IF FEMALE: yes, outcome of pregnancy
Live birth 2 Fetal death 23b. Was decedent pregnant in the past 12 months? 23d. Date of delivery 3 Ectopic pregnancy Month Year 4 Pregnant at time of death 5 ☐ Other (specify) 1 ☐ Yes 2 ☐ No detached 9 Unknown 9 I Inknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I 23e. Did tobacco use contribute to the cause of death? Obstructive 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has autopsy 2 No 1 ☐ Yes 2 ☐ No 1 □ Yes Be 25. Was case referred to medica 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) ij 1₽Yes 2 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To filled in by the funeral 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of 28d. Describe how injury occurred Injury at Work? 1 Natural 5 Pending 1 ☐ Yes 2 ☐ No 2 Accident investigation 3 🖺 Suicide 6 Could not be determined 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 - Homicide Medical 29a. Certifier 1 🗆 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. ely 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only

To the within 2

State Registrar Date filed (Month, Day, DEC 2 3 200

SAL Vado

29b. Signature and title of certifier

3001 Hos 32. Registrar's Signatur

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

29c. License number

29d. Date signed (Month, Day, Year)

2009

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene 2 0 0 9

Certificate of Death

Reg. No.

		•	1 - For State Registrar			,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,	Cer	tificate of L	Death	,	Reg. No.		42333
	Physicia	n/	1. Decedent's Name (First, Mic	die, Las	•					2. Date of De		/ Xear	3. Time of Death
	Medic	al	4. F W. All Control of the Aller				Carpa					, 200 ⁹	20:0%
	Examin	er	4a. Facility Name (if not institut					4b. City, Town, or		th		County of Death	
	Funeral		Washington A 5. Social Security Number	6 5	2V 7	PITAL Age (In yrs. I	ast birthday)	Tacoma P	If Under 24 Hrs		rth	ntgomery g. Birthp	lace (State or Fereign
	Director		224-57-8864	1	_ м 2 ² Б г ′′		74 Yrs.	Months Days	Hours Min	. (Month, Da	ay, Year) 19	Count	El Salvad
	how at	. l	Usual Residence of Decedent 10a. State 10b. Cour	ity		10c, Cit	y, Town or Lo	cation				10	Od. Inside City Limits
	larylar 3a-fsl ified	ecto	Virginia Fair	fax			ringfi						1 ☒ Yes 2 ☐ No
	or 28	Dir	10e. Street and Number					10f. Zip Code			10g. Citi	izen of What Count	try?
	ıs 23a ıust b	Funeral Director	62	18 E	oneer I	rive		22150			El S	alvador	
	death r item iner n	/ Fui	11. Marital Status		12. Was Decede Armed Force 1 \(\sum \) Yes 2	nt Ever in U.S	3. 13. \	Was Decedent of Hi f Yes, specify Cuba	ispanic Origin? (S an, Mexican, Puer	Specify Yes or No- to Rican, etc.)		14. Race - America Black, White, e	
20	e filed within 72 hours after death with the Maryland tal Hygiene. ad other than "natural", or items 23a or 28a-f show od other than "natural", or items 23a or 28a-f show event, the Medical Examiner must be notified at	d by	1 ☐ Never Married 2 🛱 N 3 ☐ Widowed 4 ☐ Divord		1 ∐ Yes 2 If Yes, Give Year or Dates		-	I 🙀 Yes 2 □ No	Specify: Sa.	lvadoria	n	Specify: White	9
ဂ ဂ	hour 'natur dical	Completed	15. Dece (Specify only hig		ducation	,	16a. Dece	dent's Usual Occup	ation	arking	16b. Ki	nd of Business Ind	ustry
2	hin 72 ne. than '	mo	Elementary/Seconday (0-12		College (1-4	or 5+)	life. D	ousekeepe	•	ткиц	Go	lf Club	
N 0	ed wit Hygie other ent, th	Be C	6:h 17. Father's Name (First, Middle	e. Last)			111	Ousekeepe		ame (First, Middle			
Maryland 21215-0036	l be fil fental rked tic ev	욘		,,	Juan A	Jaco	bo			ANTONIA			
ar Z	should and N is ma aumar		19a. Informant's Name/Relatio	nship (T)	pe, Print)			-				Town, State, Zip C	
≥ ″	und 2 : fealth im 27 her tr		Jose Saul Car	pano) (Hı	sband	1		Drive,	Springfi		VA,22150	
סר	ige 1 and Int of H		20a. Method of Disposition 1 Burial 2 Crematic			ate C	emetery, cren	sition (Name of natory or other plac		Date		ocation - City or Tov	dor
saitimore,	nit. Pa artme ortani injury		4 Donation 5 Othe			Jar		mpo Amor					, El Salva Latinos, I
ñ	permit. Page 1 and 2 should be filec Department of Health and Mehrtal H Important. If item 27 is marked ot any injury or other traumatic even once.		Dandelse	h	B. Juli	5						, DC20011	
			23a. Part 1. Enter the disease, shock, or heart failure. Lis		no cause on each	lino		-	_				Approximate Interval Between
F	nysician/	i	Immediate Cause (Final disease or condition		ATK	SRO	2500	SROTE	C /Y	EME!	SE	SUASE	Onset and Death
	Medical Examiner		resulting in death)	ſ	Due to (or	as a consequ	uence of):						
		ner	Sequentially list conditions,	J	b. Due to (or	as a consequ							
	outed nd ransit	cami	Sequentially list conditions, If any, leading to immediate cause. Enter Underlying Cause (Disease or linjury that initiated events resulting in death) Last Due to (or as a consequence of): Due to (or as a consequence of):										
	e exec cian al urial-t												
2/00	ificate be executed g physician and as the burial-transit	Medical			d						_		
8	certifi inding use as		IF FEMALE: 23b. Was decedent pregnant		23c. If yes, outcor			7 5-4				23d. Date of delive	ry
ZOZ	death ne atte ed for	Physician/	in the past 12 months? 1 ☐ Yes 2 No 9 ☐ Unknown		4 Pregnar	t at time of o		Ectopic pregnand Other (specify)				Month	Day Year
5	at the d by th etach		Part II. Other significant cond	itions co			ulting in the u	nderlying cause giv	ven in Part I	220 Didd	abassa u	se contribute to the	a cause of death?
ν, T	res th signed	d by			Jimbaning to doct								ably 4 Unknown
ecords,	requi	lete								24a. Was	an	24b. Were autop	sy findings available
e S	he lav te has age 2	Completed									psy ormed? 2 No	death?	npletion of cause of
T T	ian: T	Be C	25. Was case referred to medic examiner?					26. Pl	ace of Death (Che		ZATINO	o r les .	2 🗆 110
VITA	hysic his ce al direc	ပ္	1 🗆 Yes 2 💢 No				ER/Outpatier		er: 4 Nursing	Home 5 Resi	dence 6	Other (Specify)	
n 01	ding F h. After t funera	ate:	27. Manner of Death Natural 5 Pen			njury Da <i>y, Year)</i>	28b. Time of injury	work		28d. Describe	how injury	occurred	
S	Attender r des t	ertificate:	3 🔲 Suicide 6 🗌 Cou	stigatior ld not b rmined	e 28e. Place of			eet, factory, office	res 2 🗆 No	28f. Location (Street and	d Number or Rural I	Route Number,
DIVISION	tal or so fter all Direction to all Dire	O	4 - Horriciae gete	mined	building,	etc. (Specify)			City or To	vn, State)		·
	Hospi 4 hou Funer ted fill	Medical	29a. Certifier 1 Certify (Check 2 Medica	ng Phys I Exami	sician: To the best ner: On the basis o	of my know	ledge, death o	occured at the time	, date and place, on, death occurred	and due to the call at the time, date	ause(s) and and place,	d manner as stated and due to the cau	i. se(s) and manner stated.
	To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours fitted est th. To the Funeral Director After this certificate has been signed by the attending physician and completed filled in by th. funeral director, page 2 should be detached for use as the burial-transit	M	only one) 3 Certify 29b. Signature and title of certify		se Practioner: To t	he best of my	/ knowledge, o	death occurred at the		lace, and due to the) and manner as sta e signed (Mo <i>pth, D</i>	se(s) and manner stated. ted.
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	7 1		30. Name and address of person				23a) (Type, F	Print)	The same	14 Rock	-/	11.10	-
14			/	00	1	COLL	NU	5, 11	KAMA	prock	/	niv.	
	Stat Registra	e	31. Date tiel (Month, Day Year	9 /	32: Regi	straris Signa	ares						

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 42600 For State Certificate of Death 2 Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) Day Month Physician. 2009 1:45 Dec. Copeland S. Delia Medical 4c. County of Death 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death Examiner Prince George's Clinton Nursing & Rehabilitation Clinton 9. Birthplace (State or Foreign Country) South Carolina If Under 1 Year If Under 24 Hrs. 8. Date of Birth
Months Days Hours Min. (Month, Day,
Oct. 1,9 7. Age (In yrs. last birthday) 5. Social Security Number Funeral Months 1 🗆 M 2 🕱 F 94 Director 578-36-1192 Usual Residence of Decedent 10d. Inside City Limits 28a-f show 10b. County 10c. City, Town or Location 2 should be filed within 72 hours after death with the Maryland th and Mental Hygiene. 27 is marked outer than "natural", or items 23a or 28a-f sho traumatic event, the Medical Examiner must be notified at 10a. State Director 1 X Yes 2 No Clinton Maryland Prince George's 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number United States Funeral 20735 9211 Stuart Lane 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 12. Was Decedent Ever in U.S. 11 Marital Status Armed Forces? 1 Never Married 2 Married Specify: Black à 1 ☐ Yes 2 A No Specify: Baltimore, Maryland 21215-0036 If Yes, Give Year or Dates 3 🔀 Widowed 4 🗌 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business Industry 15 Decedent's Education (Specify only highest grade completed) College (1-4 or 5+) Government Elementary/Seconday (0-12) Maid Be 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Lusinda Rutherford ည Allen Smith 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 7405 Grange Hall_Drive, Ft. Washington, Md. 20744 f Health a Eldridge Bolling, Jr./ Son injury or other 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition Page 1 Department of H Important: If its any injury or of December Burial 2 ☐ Cremation 3 ☐ Removal from State Harmony Landover, Maryland 4 ☐ Donation 5 ☐ Other (Specify) 18**,**2009 21. Signature of Juneral Service Licenses 22. Name and Address of Facility Stewart Funeral Home, Inc. 4001 Benning Rd. NE Washington, DC 23a. Part 1. The disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ Arrthythmia disease or condition resulting in death) Medical Due to (or as a consequence of) Examiner Atrial Fibrillation Sequentially list conditions, Due to (or as a consequence of) Examine if any, leading to immediate cause. Enter Underlying Cause (Disease or linjury Crebral Vascular Accident physician and s the burial-trans that initiated events Due to (or as a consequence of) resulting in death) Last Completed by Physician/Medical To the Hospital or Attending Physician: The law requires that the death certificate be End Stage Renal Disease Box 68760 attending p IF FEMALE 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Dav Month in the past 12 months?
1 \(\subseteq \) Yes 2 \(\overline{\mathbb{X}} \) No 5 Other (specify) 4 Pregnant 9 Unknown Pregnant at time of death signed by the a 9 Unknown P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 X No 3 ☐ Probably 4 ☐ Unknown Division of Vital Records, 24b. Were autopsy findings available prior to completion of cause of 24a. Was an autopsy page 2 s performed' death? Yes 2 XNo 1 ☐ Yes 2 🗓 No 26. Place of Death (Check only one) To Be 25. Was case referred to medical examiner? Other: 4 X Nursing Home 5 - Residence 6 - Other (Specify) Hospital: 2 🛛 No 1 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred 27. Manner of Death Certificate: injury 5 Pending 1 XNatural 1 ☐ Yes 2 ☐ No 2 Accident
3 Suicide Investigation within 24 hours after death

To the Funeral Director, completed filled in by the 6 Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide determined Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 🗌 only one) 29d. Date signed (Month, Day, Year) 29c License number 29b. Signature and title of certifie December 17, 2009 D0025640 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 20735 7801 Old Branch Ave. # 409 Clinton, Maryland Khosrow Davachi M.D. 31. Date filed (Month, Day, Year) 32. Registrar's Signatur State DEC 2 3 2009 Registrar

DHMH 17 Rev 7/2009

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

			1 - For State Registrar	State of Ma	aryland		artmen <i>rtificate</i>			and M		giene Z	2009	42601
	Physici /Medio		Decedent's Name (First, Middle, Last) MARIA GUISEPPINA	CIFFOL	ILLI						2. Date of Dea		,2009	3. Time of Death 4:35A. M
	Examir	er	4a. Facility Name (If not institution, give str Adelphi House				Ade	lphi				Pr:		eorge's
	Funeral Director			7. Ag	e (In yrs. la 7		If Under Months	1 Year Days	If Under 2 Hours	Min.	8. Date of Birt Month, Day Jan • 10	, 19 32	9. Birth	place (State or Foreign ptry)
	Maryland a-f show	ctor	Usual Residence of Decedent 10a. State 10b. County Maryland Prince Ge	orge's		Town or Local							1	0d. Inside City Limits 1 □Yes 2 ☒ No
	h with the 23a or 28	Funeral Director	10e. Street and Number 4910 Brandon Lane				10f. Zip 207					10g. Citizen Italy	of What Coul	ntry?
036	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Everning munt be notified at once.		11. Marital Status 1☐ Never Married 2☐ Married 3 ☑ Widowed 4 ☐ Divorced	. Was Decedent Armed Forces? 1 Yes 2 N If Yes, Give Year or Dates:	Ever in U.S.	l:	Was Deced f Yes, spec		ispanic Orion, Mexican Specify:	gin? (Spe , Puerto I	ecify Yes or No- Rican, etc.)		Race - Americ Black, White, ecify:	
altimore, Maryland 21215-0036	filed within 72 ho Hyglene. other than "natul ent, the Medical	To Be Completed by	15. Decedent's Educa (Specify only highest grade of Elementary/Secondary (0-12)	tion ompleted) College (1-4or 5	+)	16a. Deced (Give life. L Seams	kind of wor OO NOT us	l Occupa k done d e retired,	ation Juring most)	of workir	ng	16b. Kind of	of Business/In	dustry
land	ild be filed fental Hyg rked othe tic event,	o Be C	17. Father's Name (First, Middle, Last) Dominic Dadamo		-		_			r's Name nk)	(First, Middle,	Maiden Sur	rname)	
, Mary	and 2 should be ealth and Mental n 27 is marked on her traumatic eve		19a. Informant's Name/Relationship (Type Michael Ciffolilli				-				Route Numbersville,			*
timore	. Pages 1 tment of H tant: If iter jury or oth		20a. Method of Disposition 1 ☒ Burial 2 ☐ Cremation 3 ☐ Rer 4 ☐ Donation 5 ☐ Other (Specify)	noval from State	20b. Pla cer Ar1:		n Nati	ona.	l Cem	eter		2010	_	own, State ton, Virginia
Bal	permit. Departr Imports any inji		21. Signature of Funeral Service Licensee	gward	et	44	100 Pc	wder	c Mil	l Roa		sville	e, PA e, Mary	land 20705
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	Examiner	Examiner	Sequentially list conditions, if any, leading to immediate Cause (Disease or injury	Due to (or as	a conseque	ence of);								
8760,	cate be executed physician and the burial-transit	dical	that initiated events resulting in death) Last	Due to (or as	a conseque	ence of):								
P.O. Box 6	To the Hospital or Attending Physician: The law requires that the death certific within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending pl completely filled in by the funeral director, page 2 should be detached for use as to	Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 ☒No 9 □ Unknown	. If yes, outcome 1 ☐ Live birth 4 ☐ Pregnant at 9 ☐ Unknown	2 Fetal c	death 3□	Ectopic pr Other (spe		′			23d	. Date of deliv Month	ery Day Year
rds, P	w requires that been signed b should be deta	by	Part II. Other significant conditions contri	buting to death bu	ut not result	ing in the un	iderlying ca	use give	en in Part I.					he cause of death?
Division of Vital Records,	in: The law re ifficate has be or, page 2 sho	Completed	25. Was case referred to medical			-						med? 2 X No	4b. Were auto prior to co death? 1 □ Yes	ppsy findings available impletion of cause of 2 XNo
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sion (tending Fleath. tor: After the funer	Certification:	27. Manner of Death 1 ☑Natural 5 ☐ Pending 2 ☐ Accident investigation 3 ☐ Suicide 6 ☐ Could not be	28a. Date of Inju (Month, Day	v, Year)	28b. Time of Injury	М		≀at ? ∕es 2 □ N	10	28d. Describe h			
DIV	oital or Al urs after o eral Direc		4 Homicide determined	28e. Place of Injubulding, etc	:. (Specify)						City or Tow	n, State)		al Route Number,
	the Hosphin 24 hother the Fune	Medical	29a. Certifier (Check only one) 1 △ Certifying Physic □ Medical Examine	: On the basis of and manner sta	examination	ledge, death on and/or inv	estigation,	in my op	pinion, deat	d place, a	ed at the time,	date and pla	ace, and due t	o the cause(s)
)	3		29b. Signature and title of certifier Phillip to 0	Pot M	٠.				2309				igned (Month, mber 16	5, 2009
			30. Name and address of person who compression with the Poth, M. Poth, M. 31. Date filed (Month, Day, Year)		Maywo	ood Av		Silv	ver Sp	pring	g, Mary	land 2	20910	
	Sta Registra		DEC 17 2009	Leneus	-	par	w							

DHMH 17 Rev 1/2001

	1 - State of Maryland / Department of Health Certificate of Death		ygiene Reg. No. 2	42602
sician	1. Decedent's Name (First, Middle, Last) Harold Fugone COPDEPMAN	2. Date of D Month	Death Day Year 4 2009	3. Time of Death 9:45 a M
edical miner	Harold Eugene CORDERMAN 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location	of Death	4 2009 4c. County of Death	
eral tor	$ \begin{array}{c ccccccccccccccccccccccccccccccccccc$	r 24 Hrs. 8 Date of B	Washington Birth Day, Year) 9. Birthpla Countr 9,1945 Mary	ace (State or Foreign
	Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location		100	d. Inside City Limits
any injury or other traditions event, the recent once. To Be Completed by Funeral Director	Maryland Washington Hagerstown			1 □Yes 27 No
Director	10e. Street and Number 10f. Zip Code		10g. Citizen of What Countr	ry?
by Funeral				
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Completed	Elementary/Secondary (0-12) College (1-4or 5+) Wite. DO NOT use retired) 9 Auto Body repair &	Ţ.	auto body r	epair
Be Co	17. Father's Name (First, Middle, Last) 18. Moth	ner's Name (First, Midd	le, Maiden Surname)	
일	Howard Luther Corderman	Rosie Vii	rginia Plunker	tt
	19a. Informant's Name/Relationship (Type. Print) Linda V. Corderman – wife 19b. Mailing Address (Street and Numb			^{Code)} 21740
	20a. Method of Disposition 20b. Place of Disposition (Name of	Date	20c. Location - City or Tow	
	1⊠Burial 2 □ Cremation 3 □ Removal from State d□ Cedar Lawn Memorial Cedar Lawn Memorial	December 8, 2009	Hagerstown, M	Maryland
	21. Signature of Funeral Service Ligenses 22. Name and Address of Facility	Minnic Minnic	h Funeral Home	3
	23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as shock, or heart failure. List only one cause on each line.	as cardiac or respiratory	1 0	=
dical Examiner	23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Due to (or as a consequence of):	as cardiac or respiratory	arrest,	and 21740 Approximate Interval Between
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Physician	
/Medical	
Examiner	

Funeral Director

death with the Maryland r than "natural", or items 23a or 28a-f show the Medical Examinar must be redfled at filed within 72 hours after permit. Pages 1 and 2 should be fill Department of Health and Mental Himportant: If Item 27 is marked ott any Injury or other traumatic even Pages 1 and 2 should be nent of Health and Mental

21215-0036

Maryland

Baltimore,

Box 68760.

P.0.

of Vital Records,

Division

Physician /Medical Examiner

and the

Hospital or Attending Physician: The law requires that the death certificate be executed certificate filled in by the funeral director, s after death. 24 hours To the within 2

For Amend Item #18 State of Maryland / Department of Health and Mental Hygiene Registrar WCHD/SH 12/23/09 per FH Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death - 20, Dorothy Η. Cunningham 2009 9:05 P M December 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Homewood Nursing Home of Williamsport Washington Co. Williamsport If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) . Social Security Number Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) Months Days Hours 485-26-3393 August 25, 1915 Iowa Usual Residence of Decedent 10b. County 10c. City, Town or Location 10d. Inside City Limits 10a. State Director Marylahd Washington Williamsport 1 XYes 2 □ No 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 16505 Virginia Avenue 21795 USA Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 No 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11 Marital Status Black, White, etc. 1 ☐ Yes 2X If Yes, Give Year or Dates: 1 ☐ Never Married 2 ☐ Married 1 □Yes & No Specify Completed by Specify: WHITE XXWidowed 4 Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) 4+ Registered Nurse Medical 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Jordon Mikes Edna Mikes Edna Martin 2 19a. Informant's Name/Relationship (Type. Print) M - 0019b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Katherine D. Zerance 13121 Gentry Drive, Hagerstown, Maryland 21742 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition January 8, 14 Burial 2 Cremation 34 Removal from State 2010 4 □ Donation 5 □ Other (Specify) Rolling Green Cemetery Camp Hill, Pennsylvania 22. Name and Address of Facility
Lochstampfor Funeral Home, Inc.
48 S. Church St., Waynesboro, PA 17268 21. Signature of Funeral Sarvice Licensee -00849 hat 23a. Part 1. Enter the disease, or complications that call shock, or heart failure. List only one cause on each the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Betweer Immediate Cause (Final disease or condition resulting in death) Dug to (or as a consequence of) trow Sequentially list conditions, if any, leading to immediate cause. Enter Underlying that initiated events resulting in death) Last Examiner Dile to (or as a consequence of) Due to (or as a consequence of) Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy

1 Live birth 2 Fetal death
4 Pregnant at time of death 23d, Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 XNo Month Day Year 5 Other (specify) □Unknown 9 Unknows significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? \$ HAUNIC 1 XYes 2 No 3 Probably 4 Unknown Be Completed 24b. Were autopsy findings available prior to completion of cause of death?
1 □Yes 2 □No 24a. Was an autopsy perform 2 **N**No 1 □Yes 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To 28a. Date of Injury (Month, Day, Year) 28b. Time of Injury 27. Manner of Death 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural 2 Accident 5 Pending investigation 1 □Yes 2 □No 6 □ Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

| Medical Examiner: On the basis of examination and/or investigating the control of the cause of 29a, Certifie Medical Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 29b. Signatu 29c._License number 29d. Date signed (Month, Day, Year) 30 Name and address

State Registrar

31. Date filed (Month, Day,

SH-10

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 2009 42604 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day Physician/ Month PM Douglas Lamar CORNELL ecembe Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Washington Washington County Hospital Hagerstown 8. Date of Birth (Month, Day, Ye Aug • 16 Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 9. Birthplace (State or Foreign **Funeral** Min. 1 € M 2 □ F Months Hours Georgia 1942 67 Director Aug. 259-50-9090 Usual Residence of Decedent show 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits 72 hours after death with the Maryland "natural", or items 23a or 28a-f sho edical Examiner must be notified at Director 1 X Yes 2 No Maryland Washington Hagerstown 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 63 S. Colonial Drive 21740 USA 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Race - American Indian. Black, White, etc Completed by 1 Never Married 2 Married 1 X Yes 2 🗌 No Baltimore, Maryland 21215-0036 1 ☐ Yes 2 🔀 No Specify: 3 Divorced Year or Dates. 1964-67 White event, the Medical 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) and Mental Hygiene. is marked other than Elementary/Seconday (0-12) College (1-4 or 5+) Correctional officer Corrections age 1 and 2 should be filed w ont of Health and Mental Hygi nt: If item 27 is marked othe y or other traumatic event, i Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ၉ William Henry Cornell Martha Allison 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 63 S. Colonial Drive, Hagerstown, Maryland 21740 Billie Arlene Cornell - Wife 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State permit. Page 1 a
Department of h
Important: If ite
any injury or ot Date cemetery, crematory or other place 1 Durial 2 X Cremation 3 Removal from State 4 Donation 5 Other (Specify) Hagerstown Crematory 12/22/09 Hagerstown, Maryland 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Minnich Funeral Home 415 E. Wilson Blvd. Hagerstown, MD. 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Onset and Death Metastalu Physician/ mon las Medical Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examine Due to (or as a consequence of): Cause (Disease or linjury that initiated events burial-transi Due to (or as a consequence of): resulting in death) Last attending physician Physician/Medical Hospital or Attending Physician: The law requires that the death certificate be Division of Vital Records, P.O. Box 68760 the as IF FEMALE: signed by the attending be detached for use 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregna 5 Other (specify) Ectopic pregnancy in the past 12 months? 4 Pregnant
9 Unknown Month Year Day Pregnant at time of death Yes 2 No 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown certificate has been si rector, page 2 should 24b. Were autopsy findings available prior to completion of cause of 24a. Was an autopsy death? 1 ☐ Yes 2 ☐ No Yes 25. Was case referred to medical within 24 hours after death.

To the Funeral Director: After this certific completed filled in by the funeral director, Be 26. Place of Death (Check only one) Hospital: Other: မ 1 Yes 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at Certificate: 28d. Describe how injury occurred work?
1 Yes 2 No Natural Accident 5 Pending iniury Investigation 3 Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined City or Town, State) Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29b. Signature and title of certifie 29d. Date signed (Month, Day, Year) 12.22.09 028365

05H3+1 State

31. Date filed (Month, Day, Year)

MAWZAA

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

treet Hagerstonn MD 32. egistrar's Signature

368

Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

			1 - For State of Maryland / Department Certifica	nt of Health and M te of Death	lental Hygien	7009 47	2605
	Physici		1. Decedent's Name (First, Middle, Last) LOUISE Elizubeth Crone		2. Date of Death Month D	Vaar	me of Death
	/Medic Examin		4a. Facility Name (If not institution, give street and number) 4b. City	, Town, or Location of Death		c. County of Death	
ł	Funeral		Marsh and American Am	er i Year If Under 24 Hrs. Days Hours Min.	8. Date of Birth (Month, Day, Yea	9. Birthplace (S	- 1
	Director		Usual Residence of Decedent	Days Hours Mill.	11-26-1921	y West VI	Minia
	aryland show	7	10a. State 10b. County 10c. City, Town or Location				ide City Limits Yes 2 □ No
	r 28a-f	Funeral Director	And Market	ip Code	10g. (Citizen of What Country?	
	s 23a o	ral D	243 North Cranberry Rd.	21157		14. Race - American Indi	
000	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Departurent of Health and Mental Hygiene. Important: If time 72 is marked other than "natural; or Itams 23a or 28a-f show any injury or other traumatic avant, Ita Madical Examination to other traumatic avant, Ita Madical Examination to other traumatic avant, Itams and Examination of the modified at once.	by Fune	11. Marital Status 1 □ Never Married 2 □ Married 3 ☑ Widowed 4 □ Divorced 12. Was Decedent Ever in U.S. Armed Forces? 1 □ Yes 2 ☒ No If Yes, Give 1 □ Yes	edent of Hispanic Origin? (Specify Cuban, Mexican, Puerto 2 ½ No Specify:	ecry Yes or No- Rican, etc.)	Black, White, etc. Specify: Wilk.	an,
5	in 72 hou "natura	Completed	15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Us (Give kind of w	ual Occupation rork done during most of worki use retired)	16b.	Kind of Business/Industry	
717	ed with ygiene. ner thar it, II e h	Comp	College (1-4or 5+)	ress	(lothing	
ושום	2 should be filed with and Mental Hygiene. Is marked other than aumatic avant, ITE N	To Be	17. Father's Name (First, Middle, Last) FVUNZ MUY fin	1 1- (e (First, Middle, Maide) Ny der	on Sumame)	
Mary	d 2 shouth and h. 7 is ma		P. L. P. Davidle	SS (Street and Number or Rura	Westminst		
ע	Pages 1 and ent of Health nt: If itam 27 ry or othar tr		20a. Method of Disposition 20b. Place of Disposition (No cemetery, crematory or	ame of Cother place)	Date 20c.	Location - City or Town, Sta	ate
	permit. Pag Departr ent Importent: any inj ry once.		'4 □ Donation 5 □ Other (Specify)	Mulic Charley 12-	19-09 6	#45buy, PA	
ă	permi Depa Impoi any ir once.		Stylen K, Miller Peters F	when I How, In.	321 Curtishe St.	1 mdpsed 111	15
	Physician /Medical Examiner		23a. Part1. Enfer the disease, or complications that caused the death. Do not enter the moshock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Due to (or as a consequence of):	Mass	or respiratory arrest,	Interv	oximate all Between and Death wouths
,	The taw requires that the death certificate be executed ate has been signed by the attending physician and page 2 should be detached for use as the burial-transit	dical Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter incertain. Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Due to (or as a consequence of): Due to (or as a consequence of):				
O. DOX 0	res that the death certifics igned by the attending pl be detached for use as t	Physician/Medical	IF FEMALE: 23b. Was decedent pregnant in the past 12 moorts? 1 □ Yes 2 □ No 9 □ Unknown 23c. If yes, outcome of pregnancy 1 □ Live birth 2 □ Fetal death 3 □ Ectopic 1 4 □ Pregnant at time of death 5 □ Other (s			23d. Date of delivery Month Day	Year
1 do, 1	w requires that been signed b should be deta	by	Part II. Other significant conditions contributing to death but not resulting in the underlying	cause given in Part I.		o use contribute to the caus 2 ₩No 3 Probably	
י שבכי	sician: The law requ certificate has been lirector, page 2 should	Completed			24a. Was an autopsy performed?		n of cause of
A 15	ysician: The is certificate ha director, page	To Be	25. Was case referred to medical examiner? 1 Yes 2 No	Other	(Check only one)	6 ☐Other (Specify)	
5 1	ng Ph (fter th				28d. Describe how in		
	<u>=</u> = = = = = = = = = = = = = = = = = =	Certification:	3 Suicide 4 Homicide 6 Could not be determined 28e. Place of Injury - At home, farm, street, factor building, etc. (Specify)	ry, office	28f. Location (Street City or Town, Sta	and Number or Rural Route ate)	Number,
:	To the Hospital within 24 hours a To the Funeral I completely filled	edical C	29a. Certifier (Check only one) 1 Certifying Physician: To the best of my knowledge, death occurre 2 Medical Examiner: On the basis of examination and/or investigation and manner stated.	d at the time, date and place, n, in my opinion, death occurr	and due to the cause ed at the time, date a	(s) and manner as stated. nd place, and due to the ca	use(s)
1	To the within To the comple	Me	29b. Signature and ittle of partifier	9c. License number	29d. C	Date signed (Month, Day, Yo	ear)
1	WJL		30. Name and address of person who complete cause of death (Item 2 a) (Type, Print)	N3459	3 Ne	cember 1	1, 2009
	15		Robert N. Kass MD 410 Malcols	D34298	ite C 1	Vestminsk	טוג מא, ע
	Sta Registr		31. Date filed (Month, Day, Year) 32. Regignar's Signature DEC 17 2009 Server A. San	w			

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. Amend Item 29d per dr., g899, U1/07 Udhb Certificate of Death Reg. No. 1 - For State Registrar 1. Decedent's Name (First, Middle, Last) 2. Date of Death Day James w 16 200 4a. Facility Name (If not institution, give street and number, 4c. County of Death 4b. City, Town, or Location of Death Harford Harford Memorial Hospital Havre de Grace Date of Birth (Month, Day, Year) 5/25/1922 9. Birthplace (State or Foreign Country) Virginia If Under 1 Year | If Under 24 Hrs. | Months | Days | Hours | Min. | 5. Social Security Number 7. Age (In yrs. last birthday) Months **X**□ M 2□ F Days 217-26-3261 Yrs. 87 Usual Residence of Decedent 10d. Inside City Limits 10b. County 10c. City, Town or Location Harford Darlington 1 □Yes 2X No 10f. Zip Code 10g. Citizen of What Country? 10e Street and Number USA 2103 Swartz Road 21034 12. Was Decedent Ever in U.S.
Armed Forces?

1 X Yes 2 □ No
If Yes, Give WWII
Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status 1 Never Married 2 Married Specify: White 1 □ Yes 🏖 No Specify: 3 Widowed 4 Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Tank Truck Driver Civil Service 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Rose Poole Thomas Copeland 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 2103 Swartz Road, Darlington, MD 21034 19a. Informant's Name/Relationship (Type. Print) Shirley C. Copeland/Wife 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition 1X Burial 2 ☐ Cremation 3 ☐ Removal from State Darlington Cem. 12/21/09 Darlington, MD 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Filmeral Service Lic 22. Name and Address of Facility Inc.600 Main St. Delta, PA 17314 C. Kobert Harkins Funeral Home, 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Due to (or as a consequence of): NEUMONIA Sequentially list conditions, if any leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last ONIC OBSTRUCTIVE LUNG DISTANCE Due to (or as a consequence of)

/Medical Examiner attending physician for use as the buria been signed by the should be detached Ö Records, Vital ð Division

Hospital or Attending To the Hospital or Attend within 24 hours after death To the Funeral Director; completely filled in by the f

Physician

/Medical

Examiner

10a. State

Director

Funeral

þ

Be Completed

2

Examiner

Jedical

Funeral

Director

ed other than "natural", or Items 23a or 28a-f show event, the Medical Examiner must be rutified at

Department of Health and Mental Higgiene. Important: If Item 27 Is marked other than any injury or other traumatic event, Inc. M. Once.

Physician

Baltimore, Maryland

Pages 1 and 2 should

ed by Physician/M	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown	23c. If yes, outcome of pregnancy 1	23d. Date of delivery Month Day Year				
	Part II. Other significant conditions	23e. Did tobacco use contribute to the cause of death? 1					
Completed		YPOTHROIDISM,	24a. Was an autopsy autopsy performed? 1 □ Yes 2 ☑ No				
	25. Was case referred to medical	26. Place of Death (eath (Check only one)				
	examiner? 1 ☐ Yes 2 ☐ No	Hospital: 1 Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 ☐ Nursing Home	e 5 Residence 6 Other (Specify)				
	27. Manner of Death 1 ➡ atural 5 ☐ Pending 2 ☐ Accident investigation	(<i>Month, Day, Year</i>) Injury Work? n M 1 ☐ Yes 2 ☐ No	d. Describe how injury occurred				
Certification	3 ☐ Suicide 6 ☐ Could not 4 ☐ Homicide determined		if. Location (Street and Number or Rural Route Number, City or Town, State)				
lical		hysician: To the best of my knowledge, death occurred at the time, date and place, ar miner: On the basis of examination and/or investigation, in my opinion, death occurred					

29c. License number

D08096

29d. Date signed (Month, Day, Year)

35 FULFORD AVE BELAIR, MD 21014

State Registrar 31. Date filed (Month, Day, Year)

29b. Signature and title of gertifier

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

when Nouvalions in Mi

10

		Please Type or Print in State of Marylai	nd / Depa	artment of F	Health and M	-	giene		10007	
		1 - State Registrar 1. Decedent's Name (First, Middle, Last)	Cei	rtificate of	Death	O Data of D	Reg. No.	009	42601	
Physi	cian	VERA N. DICKERSON					2. Date of Death Month Day Year DECEMBER 30 2009 8:45 p ^M			
/Med Exam		4a. Facility Name (If not institution, give street and number)	4b. City, Town, or Location of Death			DECEM.		nty of Death	8:45 p ^M	
=xam	iner	Chester River Manor			tertown		Ker			
Funera	al		. last birthday)	If Under 1 Year Months Days		8. Date of Bi (Month, D	rth		ace (State or Foreign	
Directo	r	221-07-8532 ^{1□ M 2} \$\footnote{1}\$ 93	Yrs.	World S Days	TIQUIS IVIII.	Dec 1		Mar	ӳland	
and w		Usual Residence of Decedent 10a. State 10b. County 10c. C	ity, Town or Lo	ocation				100	d. Inside City Limits	
Mary -f sh	ģ	MD Kent C	heste:	rtown					1 ⊈Yes 2 □ No	
h the	irec	10e. Street and Number	inco cc.	10f. Zip Code			10g. Citizen	of What Countr	ry?	
th wit	Funeral Director	300 Hadaway Dr. Apt 8B		21620	O		U.S.A	Α.		
tems	nne	11. Marital Status 12. Was Decedent Ever in Under Armed Forces?	J.S. 13.	Was Decedent of H	lispanic Origin? (Sp an, Mexican, Puerto	ecify Yes or No Rican, etc.)	0- 14. F	Race - America Black, White, et		
UUSO nours afte ural", or i	by F	1 ☐ Never Married 2 ☐ Married 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates:		1 □Yes 2 🙀 No	Specify:		Spe	ecify: Wh	ite	
2 hour	ed	15. Decedent's Education	16a, Dece	dent's Usual Occup	pation		16b. Kind o	f Business/Indu	ustry	
hin 73	ple	(Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+)	life.	DO NOT use retire		•				
o 6 16 15 10-0050 filed within 72 hours after death with the Maryland Hygiene. then "natural", or items 23a or 23a-f show ent, the Medical Evanther must be notified at	Completed	2	Senio	or Admir	nistrati				Dept.	
be file tal H d oth	Be	17. Father's Name (First, Middle, Last)			18. Mother's Nam	- , . ,	,			
r ylc	၉	James B. Newnam	1		Vera E					
d 2 sl d 2 sl th an traul		19a. Informant's Name/Relationship (Type. Print) Barbara Myers (daughter)			and Number or Ru um Hollo					
f Hea			Place of Dispo	sition (Name of	1	Date		on - City or Tow		
mit. Pages partment of portant: If it y Injury or o		1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify)		natory or other place n Cemet	ery 1/2	/2010	Crum	pton,	MD.	
paritimore, Maryjarina ZIZIS-0050 permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any Injury or other traumatic event, the Modical Evantine must be notified at	형	21. Signature of Funeral Service Licensee	22	2. Name and Addre	ss of Facility		C C L	1 T	Schaech	
0 89E	8	MO MO	0510	118 West	Cross	St. G	alena,	MD	21635	
		23a. Part 1 Enter ne disease, or complications that caused the deas slock, or neart failure. List only one cluse on each line.							Approximate Interval Between	
Physician	-	Immediate Cose (Final disease or condition	lerofi	c. Vas	cula: d	Wens	e		Onset and Death	
/Medica Examine	•	resulting in death) Due to (or as a conse	quence of):					7		
		Sequentially list conditions, if any, leading to infinediate Due to (of as a conse	ouenes of							
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be executed ician and ourial-transit		resulting in death) Last Due to (or as a conse	quence of):				·			
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ertific ding p	Med	IF FEMALE:								
attend for us	ian/	23b. Was decedent pregnant in the past 12 gronths? 1	tal death 3 [Ectopic pregnanc	:y		23d.	Date of deliver Month	ry Day Year	
y the d	lysic	1 Yes 2 No 9 Unknown	deam 5L	Other (specify) _						
that ned b		Part II. Other significant conditions contributing to death but not re	sulting in the u	nderlying cause giv	en in Part I.	23e. Did	tobacco use c	ontribute to the	e cause of death?	
equires	ed by					1 🗆	Yes 2 N	o 3 ☐ Proba	ably 4 🗌 Unknown	
aw re	plet					24a. Was		b. Were autop	sy findings available	
The The ate ha	Completed					auto perf 1 ☐ Yes	ormed? 2 MNo	death?	npletion of cause of 2 □ No	
clan; ertific ector,	Be (25. Was case referred to medical examiner?			26. Place of Dea		_/_			
hysl this o	은	1 ☐ Yes 2 No Hospital: 1 ☐ Inpatient 2 ☐			4 Nursing H			Other (Specify,)	
ding I	ion	27. Manner of Death 1 Natural 5 ☐ Pending (Month, Day, Year)	28b. Time o Injury	Wor		28d. Describe	how injury oc	curred		
Attended death death ctor:	ficat	2 Accident investigation 3 ☐ Suicide 6 ☐ Could not be determined determined	nome farm str		Yes 2 □No	28f. Location	(Street and No	ımber or Rural	Route Number,	
al or A	Certification:	4 Homicide determined building, etc. (Special	ify)	out, tactory, critico			wn, State)	imber of Harar	Troute Number,	
To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the tuneral director, page 2 should be detached for use as the burial-transit	Medical C	29a. Certifier (Check only one) Certifying Physician: To the best of my kn and manner stated.	owledge, deat nation and/or in	h occurred at the tinvestigation, in my	me, date and place opinion, death occu	, and due to th	e cause(s) and e, date and pla	d manner as sta ce, and due to	ated. the cause(s)	
To the withing To the Comp	Me	29b. Signature and title of certifier		29c. Licens	se number		29d. Date sig	gned (Month, D	Day, Year)	
		16 WU Den -ma	>	216	483		12-	31 - 0	9	
6	,	30. Name and address of person who completed cause of death (Ite		,	,				*	
		Wayne D. Benjamin, M.D. 31. Date filed (Month, Day, Year) 32. Registrar's Sign	6602	Church	Hill R'd	. Ches	sterto	wn, MI	21620	
S Regis	tate strar			0						
DHMH 17 Rev 1		JAN 0 7 2010 Semi S.	pad							

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene 109 42608

		1 - For State Registrar	e of Maryland / Depa <i>Cer</i>	tificate of i		•	glei <i>je</i> () ()) Reg. No.	42000
Physic	ian	Decedent's Name (First, Middle, Last)				2. Date of De	Day Yes	
Physic /Medi		Allen R. Davi			Landing (David		10 County of D	
Exami	ner	4a. Facility Name (If not institution, give street and	d number)	· '	Location of Death		4c. County of D	George's
Funeral		6915 Sunnyside Lane 5. Social Security Number 6. Sex	7. Age (In yrs. last birthday)	Fort Was	If Under 24 Hrs.	8. Date of Birt		Birtholace (State or Foreign
Director		472-14-8955 X M 2	F 93 Yrs.	Months Days	Hours Min.	8. Date of Bird (Month, Da Feb. 26,	1916 Wi	Country) SCONSIN
/land		10a. State 10b. County	10c. City, Town or Lo	cation				10d. Inside City Limits
Mary a-f st	to	Maryland Prince Georg	e's Fort Wash	ington				1 ☐ Yes 2 ² ☐ No
or 28	Oire	10e. Street and Number		10f. Zip Code			10g. Citizen of What	Country?
ath w	rail	6915 Sunnyside Lane		207			USA	mariana ladina
s 1 and 2 should be filed within 72 hours after death with the Maryland if Health and Mental Hygiene. Item 27 is marked other than "naturel", or Items 23e or 28e-f show other traumatic event, the Medical Examiner must be notified at	by Funeral Director	1 Never Married 2 Married 1 1	res 2 No 1942	Was Decedent of H f Yes, specify Cuba 1 ☐ Yes 2 🛣 No	ispanic Origin? (Sp in, Mexican, Puerto Specify:	pecify Yes of No Pican, etc.)	Black, W	merican Indian, /hite, etc. White
thour sturet	edt	15. Decedent's Education		dent's Usual Occup	ation		16b. Kind of Busine	
hin 72 nn "na Media	piet	(Specify only highest grade completed in the complete state of the	ge (1-4or 5+) (Give life. L	kind of work done of DO NOT use retired	during most of won ii)	king		
ad wil	Completed		5+ Meteor	rologist			Federal G	overnment
2 should be filed within and Mental Hygiene. Is marked othar than sumatic event, the Me	Be	17. Father's Name (First, Middle, Last)	D - •		18. Mother's Nam Bess:	_	Maiden Sumame)	
Men Men Marke Marke	2	Frank	Davis	A 14 (C44			gers	in Zin Codol
		19a. Informant's Name/Relationship (Type, Print Daphne J. Ceccone – D					er, City or Town, Stat MD 20861	e, zip codej
1 and 2 Health tem 27 Ither tre		20a. Method of Disposition	20b. Place of Dispo	sition (Name of		Date	20c. Location - City	or Town, State
ages ant of nt: If ii		1 ☐ Burial 2 ♣ Cremation 3 ☐ Removal : '4 ☐ Donation 5 ☐ Other (Specify)	rom State Kalas Cr	natory`or other plac ematory	12/2	3/2009	Edgewater	, MD
permit. Pages 1 and 2 Department of Health a Important: If item 27 it any injury or other tra		21. Signature of Funeral Service Licensee	22	2. Name and Addre	ss of Facility Ger	orge P.	Kalas Fun Hill, MD 2	eral Home,P.A.
		23a. Part1. Enter the disease, or complications to	hat caused the death. Do not ent					Approximate
Physician		shock, or heart failure. List only one cause Immediate Cause (Final	on each line. TheroscleroTic	Carlo	were . P.	He	+ Direc	Interval Between Onset and Death
/Medical		disease or condition resulting in death)	e to (or as a consequence of):	0-746	1657 61620	w . / ~	1 213 -3	<u> </u>
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that the by detac		Part II. Other significant conditions contributing	to death but not resulting in the u	nderlying cause giv	en in Part I.	23e. Did t	obacco use contribut	te to the cause of death?
requires een signe	d by					1 🗆	Yes 2□No 3□	Probably 4 Unknown
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sician: The law s certificate has t lirector, page 2 s	шо					autor perfo	ormed? deat	to completion of cause of h? Yes 2□ No
ian: rtifica	BeC	25. Was case referred to medical			26. Place of Dea			
hysic his ce I direc	To	examiner? 1 Yes 2 No Hospital:	1 ☐ Inpatient 2 ☐ ER/Outpatien	nt 3□ DOA Oth	er: 4 🗌 Nursing H	ome 5 Resi	dence 6 Other (Specify)
ding Phys	on:	27. Manner of Death 28a. I 1 ☐ Natural 5 ☐ Pending	Date of Injury 28b. Time of (Month, Day Year) Injury	Wor	k?	28d. Describe	how injury occurred	
ttand death stor: /	cat	2 ☐ Accident investigation 3 ☐ Suicide 6 ☐ Could not be	Place of Injury - At home, farm, str	17	Yes 2 □No	28f Location /	Street and Number o	r Rural Route Number,
after Direction by	Certification:	determined 200.	ouilding, etc. (Specify)	eet, ractory, office		City or To		, , , , , , , , , , , , , , , , , , , ,
To the Hospital or Attanding Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit	edical C	(Check only 2 Medical Examiner: On	o the best of my knowledge, death the basis of examination and/or in manner stated.					
o the ithin (o the omple	Mec	29b. Signature and title of certifier		29c. Licens	e number		29d. Date signed (N	fonth, Day, Year)
⊢ s ⊢ ō		Alada Ala	ento Do	Ho	5592	>	December	V27, 2009
10+,		30. Name and address of person who completed	_ 1/	Print)			/ /	122,2009
/ 1/		Solvator Sy/ veste		si Tal	Drive	Chev	ery M	19my/ord
St Regist	ate	DEC 2 3 2009	32. Registrar's Signature				- /	_

09-09791	
James Day	

State of Maryland / Department of Health and Mental Hygiene 2009 1- For State Certificate of Death Reg. No Registrar 2 Date of Death Time of Death Decedent's Name (First, Middle.Last) Physician/ Month Day December 16, 2009 1203 hrs Medical Examiner JAMES DAY 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (if not institution, give street and number) Cheverly Prince George's Prince George's Hospital Center 8. Date of Birth(MM/DD/YYYY)

AUG. 17 1955

8. Birthplace (State or Foreign INDIANA Country) If Under 1 Year If Under 24Hrs. 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** Months Days Hours AUG. 17 1955 Director 1 **X**M 2 F 54 579-74-5885 Usual Residence of Decedent 10d Inside City Limits 10c. City, Town or Location in.y 10a State 1 X Yes 2 No 23a or 28a-f show notified at once. HYATTSVILLE PRINCE GEORGE'S remit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland spartment of Health and Mental Hygiene. MD Director 10g. Citizen of What Country? 10e. Street and Numbe 10f. Zip Code USA 20785 3412 DODGE PARK ROAD # 104 14. Race - American Indian, Black Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-11. Marital Status 12. Was Decedent Ever in U.S. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) White, etc. Armed Forces 1 Never Married 2 XMarried 1X Yes Specify: BLACK If Yes. Give Year 1 Yes 2 No specify: 3 Widowed Divorced ð 16a. Decedent's Usual Occupation (Give kind of work done 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Completed during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) PRIVATE TRUCK DRIVER 11th 18.Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) SHIRLEY COUSINS Be JAMES R. DAY SR. 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 20785 19a. Informant's Name/Relationship (Type, Print) 3412 DODGE PARK RD # 104 HYATTSVILLE, MARYLAND PAMELA A. FLETCHER-DAY/WIFE 20c. Location - City or Town, State 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, Date Baltimore, crematory or other place) XBurial 2 Cremation 3 VETERANS CEMETERY 12/29/09 CHELTENHAM, MARYLAND MD Donation 5 Other Specify J. B. JENKINS FUNERAL HOME 22. Name and Address of Facility 21. Signature of Funcial Service Licenses 7474 LANDOVER ROAD LANDOVER, MARYLAND 20785 Approximate Interval 23a. Han I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart Physician Between Onset and one cause on each line Medical Death Atherosclerotic Cardiovascular Disease Immediate Cause (Final disease Examiner or condition resulting in death) Due to (or as a consequence of): Sequentially list conditions, Due to (or as a consequence of) Examiner if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated Due to (or as a consequence of): events resulting in death) Last Physician/Medical **AMENDED** UNPENDED signed by the attending physician be detached for use as the burial The law requires that the death certificate be Box 68760. 23d. Date of delivery 23c. If yes, outcome of pregnancy IF FEMALE 23b. Was decedent pregnant in the Year 3 Ectopic pregnancy Month Day Live birth Fetal death past 12 months' Pregnant at time of death 5 Other (Specify) 1 Yes 2 No 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. P.O. ò 1 Yes 2 No 3 Probably 4 V Unknown history of leukemia Completed of Vital Records, 24b. Were autopsy findings available 24a Was ar prior to completion of cause of autopsy performed? death? 1 ✓ Yes 2 No 1 🗸 Yes 2 No certificate 26.Place of Death (Check only one 25. Was case referred to medical Be Other Nursing Home 5 Residence 6 Other 2 Z ER/Outpatient 3 DOA Inpatient this 1 🗸 Yes ٩ No 28d. Describe how injury occurred 28a. Date of Injury (Month, Day, Year) 28b. Time of Injury 28c. Injury at Work? After 27. Manner of Death 1 V Natural Division Yes 2 No Pending Funeral Director; 2 Accident Investigation 28f. Location (Street and Number or Rural Route Number, City 28e. Place of Injury - At home, farm, street, factory, office building, etc. 3 Suicide Could not be or Town, State) determined Homicide 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) Fo the and manner stated 29d. Date signed (Month, Day, Year) 29c. License numbe OCME O.C.M.E. December 17, 2009 address of person who completed cause of death (Item 23a) Assistant Medical Examiner 111 Penn Street, Baltimore, MD 21201 Theodore M. King, Jr., MD.

Registrar DHMH 17 Rev 1/2001 OCME 2006

State

State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month **Physician** Mary Louise Day A^{M} 2009 1:00 December /Medical 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) 4c. County of Death Examiner <u>5555 Friendship</u> Blvd #524 Chevy Chase Montgomery 8. Date of Birth O Month 1 234, 1991 9 Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year | If Under 24 Hrs. 9. Birthplace (State or Foreign **Funeral** Min. Months Days Hours 90 Missouri 486-20-1825 Director Usual Residence of Decedent 10b. County 10c. City, Town or Location 10d. Inside City Limits 10a. State show s 23a or 28a-f short Director Chevy Chase 1X Yes 2 □ No MD Montgomery 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 5555 Friendship Blvd #524 United States 20815 Funeral ed other than "natural", or items event, the Medical Evaluates or 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian. Armed Forces Black, White, etc. 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: 1 Never Married 2 Married , or Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify: Specify: White þ 3 Widowed 4 Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 721 (Give kind of work done during most of working life. DO NOT use retired) permit. Pages 1 and 2 should be filed within Department of Health and Mental Hygiene. Important; If item 27 is marked other than any injury or other traumatic event, the Me Elementary/Secondary (0-12) College (1-4or 5+) Fine Art Appraiser Fine Art 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be ၉ Joseph Muldoon Dorothy Lang 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 5555 Friedship Blvd #524 Chevy Chase, MD 20815 Richard D. Day/Husband 20a. Method of Disposition
1 ☐ Burial 2 🖸 Cremation 3 ☐ Removal from State 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State National Crematory Falls Church, VA 12-17-09 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral 22. Name and Address of Facility Joseph Gawler's Sons Inc. 5130 Wisconsin Ave. NW Washington, DC 20016 23a. Part 1. Enter the disease or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** Pneumonia disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner 10 Years Dementia Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examine law requires that the death certificate be executed physician and s the burial-trans Due to (or as a consequence of): Box 68760, Physician/Medical attending ph for use as the IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? 1 □ Yes 2 ☒No Month Year 5 Other (specify) P.0. 9 Unknown signed I Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, ģ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 X Unknown Completed 24a. Was an Were autopsy findings available prior to completion of cause of death? cate has l , page 2 s autopsy performed Hospital or Attending Physician: The certificate 1 ☐ Yes 2 ☐ No 1 ∐Yes 2 💢 No director, 25. Was case referred to medical Be 26. Place of Death (Check only one) Other: 4 ☐ Nursing Home 5 1 Residence 6 ☐ Other (Specify) 1∐ Yes 2 ⋤ No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA ဠ 28a. Date of Injury (Month, Day, Year) After the 27. Manner of Death 1 Matural 28b. Time of 28d. Describe how injury occurred Certification: 28c. Injury at Work? 5 Pending 124 hours after death.

Re Funeral Director: A pletely filled in by the fu 1 ☐ Yes 2 ☐ No 2 Accident investigation ☐Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) determined 4 Homicide to the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner. On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Medical 29a. Certifier npletely (Check only one) within 2. 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 29c. License number Dec. 09, 2009 D10030 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) David Edward Rogers MD 5530 Wisconsin Ave. #1400 Chevy Chase, MD 20815 31. Date filed (Month, Day, Year) 32 Registrar's Signature State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ 2:22 PM Frederick Taylor Jecember 2009 Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Washington Washington County Hospital Hagerstown If Under 1 Year | If Under 24 Hrs.
Months | Days | Hours | Min. 8. Date of Birth 9. Birthplace (State or Foreign Social Security Number 7. Age (In vrs. last birthday) Funeral Oct. 7, 1935 1 X M 2 🗆 Days Maryland Director 214-34-9739 74 Usual Residence of Decedent 10d. Inside City Limits 10a, State 10c. City, Town or Location must be notified at Director 28a-f 1 XYes 2 No Maryland Washington Hagerstown 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 6 23a Funeral USA 21740 165 Chantilly Court ıral", or items 2 I Examiner mus 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. 11. Marital Status permit. Page 1 and 2 should be filed within 72 hours after deat Department of Health and Mental Hygiene. Important: If item 27 is marked other the any injury or other trainment. Armed Forces?
1 X Yes 2 \(\subseteq \text{No} \) 1958 Black, White, etc. 1 Never Married 2 Married þ 1 Yes 2 No Specify: If Yes Give Completed 3 Divorced 4 Divorced Year or Dates. White 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) 12 Teacher/Administrator Education Be 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) ပ္ <u>Catherine</u> Matilda Allen Downs, Sr. 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 165 Chantilly Court Hagerstown, Maryland Rita M. Downs - Wife 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State ☐Burial 2 ☐ Cremation 3 ☐ Removal from State Dec.22,2009 Williamsport, Maryland 4 Donation 5 Other (Specify) Greenlawn Mem. Park Osborne Aluneral, Home, P.A. 21. Sonature Funeral S is ice 425 S. Conococheague St. Williamsport, MD 21795 Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ JFIKS disease or condition Medical resulting in death) Examiner SCHEMIC Sequentially net conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or linjury that initiated events resulting in death) Last Examine Due to (or as a consequence of) ORONARY burial-1 attending physiciar Physician/Medical Hospital or Attending Physician: The law requires that the death certificate be P.O. Box 68760 the as IF FEMALE: Live Birth 2 Fetal death nse 23d Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months?
1 Yes 2 No Dav detached for 5 Other (specify) 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of __ath? þ page 2 should be Division of Vital Records, 1 Yes 3 Probably 4 Unknown Be Completed 24b. Were autopsy findings available prior to completion of cause of 24a. Was an MALN UTRITION has autopsy performed death? 1 ☐ Yes 2 ☐ No ARCINOMA 25. Was case referred to medical 26. Place of Death (Check only one) funeral director, examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospita 2 1 Yes 2 🗆 No 1 Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 28c. Injury at work? 1 ☐ Yes 2 ☐ No 27. Manner of Death 28a. Date of injury 28b. Time of Certificate: 28d. Describe how injury occurred 1 Natural (Month, Day, Year) injury 5 Pending s after death. Investigation Accident within 24 hours after dear To the Funeral Director completed filled in by the Sulcide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 3 ☐ Suiciae 4 ☐ Homicide 28f. Location (Street and Number or Rural Route Number, determined City or Town, State) Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifie Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Cortifying Nurse Practioner: To the best of my-local death occurred at the time, date and due to the name as and manner as maked. (Check

State Registrar

2H8+1

29b. Signature and title of certifier

30. Name and address of person who PAMELA

DEC 22

31. Date filed (Month, Day, Year)

DHMH 17 Rev 7/2009

completed cause of death (Item 23a) (Type, Print)

PORD

Registrar's Signature

29c. License number

110

D38892 UITE

130

MEDICAL

29d. Date signed (Month, Day, Year)

State of Maryland / Department of Health and Mental Hygiene 2009 1- For State Certificate of Death Registrar 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Month Day December 17, 2009 0838 hrs Medical Examiner EPLING DANIEL **JESS** 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Johns Hopkins Hospital Baltimore 5. Social Security Number 8. Date of Birth(MM/DD/YYYY) 9, Birthplace (State or If Under 1 Year If Under 24Hrs. . Age (In yrs. last birthday) **Funeral** Months Min Days Hours Director Country) Virginia February 24,1986 231-47-3106 1 X M 2 F 23 Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits s 23a or 28a-f show notified at once. 1 Yes 2 X No Fairfax Falls Church Virginia Pages I and 2 should be filed within 72 hours after death with the Maryland Director 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? **USA** 22043 2045 Greenwich St. Funeral 11. Marital Status 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No 14. Race - American Indian, Black, 27 is marked other than "natural", or items imatic event, the Medical Examiner must be If Yes, specify Cuban, Mexican, Puerto Rican, etc.) White, etc. 1 X Never Married 2 Married 2 X No Yes Specify: White 1 Yes 2 X No specify: 3 Widowed 4 Divorced If Yes. Give Year þ 16a. Decedent's Usual Occupation (Give kind of work done 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Completed during most of working life. DO NOT use retired) Elementary/Secondary (0-12) 21215-0036 Administrative Assistant Church of Health and Mental Hygiene.

1: If item 27 is marked other the other than the Med. 17. Father's Name (First, Middle, Last) 18.Mother's Name (First, Middle, Maiden Surname) Be Gary Edward Epling Mary Elizabeth Hollar 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Baltimore, MD 132 Rochelle Ave. Philadelphia, PA 19128 David Hollar 20c. Location - City or Town, State 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) X Burial 2 Cremation 3 Removal from State Falls Church, Virginia 12/28/2009 Oakwood Cemetery Donation 5 Other Specify 22. Name and Address of Facility nature of Funeral Service Licensee Murphy Funeral Home 1102 W. Broad St. Falls Church, Virginia 22046 Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart Approximate Interval Physician Between Onset and failure. List only one cause on each line /Medical Death a Complications of Danon Disease Immediate Cause (Final disease Examiner or condition resulting in death) Due to (or as a consequence of): Sequentially list conditions, if any, leading to immediate Due to (or as a consequence of): Examiner cause. Enter Underlying Cause (Disease or injury that initiated Due to (or as a consequence of): events resulting in death) Last the Hospital or Attending Physician: The law requires that the death certificate be executed and trans. Physician/Medical physician the burial -UNPENDED AMENDED Box 68760, IF FEMALE 23c. If yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant in the 3 Ectopic pregnancy Day Month Yea 1 Live birth Fetal death past 12 months? Pregnant at time of death Other (Specify) 1 Yes 2 No 9 Unknown 9 Unknown Division of Vital Records, P.O. Part II. Other significant conditions 23e. Did tobacco use contribute to the cause of death? contributing to death but not resulting in the underlying cause given in Part I. þ 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available 24a Was an prior to completion of cause of autopsy death? performed? ✓ Yes 2 No 25 Was case referred to medical 26.Place of Death (Check only one) Be examiner? Hospital: 1 🗸 Inpatient 2 Other Nursing Home 5 Residence 6 DOA ER/Outpatient 3 this 1 🗸 Yes 28a. Date of Injury (Month, Day, Year) After 27. Manner of Death 28b. Time of Injury 28c. Injury at Work? 28d. Describe how injury occurred 1 🗸 Natural Yes 2 No Pending the Accident Investigation completely filled in by 28e. Place of Injury - At home, farm, street, factory, office building, etc. 28f. Location (Street and Number or Rural Route Number, City Could not be Suicide determined (Specify) Homicide 29a. Certifier (Check only Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 29b. Sign and title of certifie 29c. License number 29d. Date signed (Month, Day, Year) O.C.M.E. December 21, 2009 30. Name and address of person who completed cause of death (Item 23a) 111 Penn Street, Baltimore, MD 21201 Laron Locke MD Assistant Medical Examiner 2. Registraris Signature State ack Registrar

DHMH 17 Rev 1/2001

OCME

ORIGINAL

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 2 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month Year **Physician** 9:45 P M Τ. 2009 EVANS DEC ELLA 16, /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City. Town, or Location of Death Examiner MARY'S HOUSE MONTGOMERY ROCKVILLE If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** Days Hours Months 1 ☐ M 2 🔯 F Director 94 SEPT. 19,1915 PA 196-22-5955 Usual Residence of Decedent the Maryland 10d. Inside City Limits 10a. State 10c. City, Town or Location 28a-f show ed other than "natural", or items 23a or 28a-f shore event, the Madical Experiment mast be notified at Y∑Yes 2 □ No Director MONTGOMERY MD. ROCKVILLE 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 72 hours after death with Funeral SHERRY CT. 20852 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black White etc. 1 ∐Yes 2 X No If Yes, Give Year or Dates; 1 Never Married 2 Married Maryland 21215-0036 1 ☐ Yes 27 No Specify 2 Specify: 3 ☑ Widowed 4 ☐ Divorced WHITE Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) RETIRED NURSE HEALTH CARE permit. Pages 1 and 2 should be filed n Department of Health and Mental Hygit Important: If item 27 is marked other i any injury or other traumatic event. 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be STEVEN 2 KRISTOFF MARY PALUSCHAK 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) MICHELE EVANS/DAUGHTER SHERRY CT., ROCKVILLE, MD. 20852 altimore, 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 ☐ Burial 2 【Cremation 3 ☐ Removal from State 4 □ Donation 5 □ Other (Specify) CHAMBERS CREMATORY 12-18-2009 RIVERDALE, MD. 21. Signature of Funeral Service Licenses 22. Name and Address of Facility CHAMBERS FUNERAL HOME & CREMATORIUM, P.A M00091 20737 5801 CLEVELAND AVE., RIVERDALE, MD. 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician CONGESTIVE HEART FAILURE disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): law requires that the death certificate be executed burial-transit Examil and Due to (or as a consequence of): Box 68760, attending physician for use as the buria Physician/Medical IF FEMALE 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 X No Month Day Year 5 Other (specify) ed by the a P.0. 9 I I Inknown signed I Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, 2 1 ☐ Yes 2 ☑ No 3 ☐ Probably 4 ☐ Unknown Completed page 2 should been 24b. Were autopsy findings available prior to completion of cause of death?
1 □ Yes 2 □ No 24a. Was an has autopsy performed? 1 Yes 2 No Hospital or Attending Physician: 24 hours after death. Funeral Director: After this certifica funeral director, 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) ASSISTED Other: 4 Nursing Home 5 Residence 6 MOther (Specify) Hospital: 1 Yes 2 No 1 Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To LIVING 28b. Time of Injury 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28c. Injury at Work? 28d. Describe how injury occurred 5 ☐ Pending investigation 1X Natural 1 ☐ Yes 2 ☐ No 2 Accident filled in by the 3 Suicide 6 ☐ Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide To the Hospital or within 24 hours at To the Funeral D 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) Medical 29a. Certifier (Check only one) and manner stated. 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 29c. License number D26259 DEC. 17, 2009

Registrar

AVA

Α. 31. Date filed (Month, Day, Year,

DEC

DHMH 17 Rev 1/2001

8218 WISCONSIN AVE. SUITE 103, BETHESDA, MD. 20814

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

M.D.

33 Registrar's Signature

KAUFMAN,

18

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day Month **Physician** PAUL FORESTA DEC. 23 ,2009 3:55P /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** CHARLES CO.NURS.& REHAB. CENTER LA PLATA CHARLES 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 1 – 15 – 1927 Birthplace (State or Foreign
Country) **Funeral** 1√2 M 2□ F Months Days Hours Min. 577-34-1442 82 Director OHIO Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits d other than "natural", or items 23a or 28a-f show event, the Medical Exanting must be notified at Director 1

Yes 2 □ No MD. CHARLES LA PLATA 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 72 hours after death with 10200 LA PLATA ROAD 20646 U.S.A. Funeral 12. Was Decedent Ever in U.S.
Armed Forces?

1 XYes 2 □ No
If ¥8s, Give
Year or Dates: WWI 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 1 ☐ Never Married 2 ☐ Married ARMY Baltimore, Maryland 21215-0036 1 □ Yes 2 □ two Specify. 2 Specify: WHITE 3 Widowed 4 Divorced WWII Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) filed within 7 I Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) PARKING ANALYST D.C.GOVT. 11th marked other 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) if and 2 should be fill Health and Mental H Be permit. Pages 1 and 2 should be Department of Health and Menta Important: If item 27 is marked any injury or other traumatic ev **GUY FORESTA** PATSY FORESTA ျှ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) HELEN FORESTA-SPOUSE 201 STARKEY COURT LA PLATA, MD. 20b. Place of Disposition (Name of cemetery, crematory or other place, 20a. Method of Disposition Date 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) METROPOLITAN CREMATORY 12-24-09 ALEX., VA. 22. Name and Address of Facility 21. Signature of Fuperal Service Licenses M00479 RAYMOND FUNERAL SERVICE, P.A. 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician heime disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, Due to (cries a consequence of): Examine il any teach of the innecta cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Physician; The law requires that the death certificate be executed burial-transi and Due to (or as a consequence of): P.O. Box 68760, physician Physician/Medical the attending ph IF FEMALE: 23c. If yes, outcome of pregnancy 23b. Was decedent pregnant 23d. Date of delivery Live birth 2 Fetal death
Pregnant at time of death 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Ye a 5 Other (specify) the 9 Unknown 9 Unknown ģ signed I Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 💢 Unknown Completed page 2 should 24a. Was an autopsy performe 24b. Were autopsy findings available prior to completion of cause of death? certificate 2 🗆 No 2) 1 Tes 1 ☐ Yes director, 25. Was case referred to medical Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 🗙 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To this 28a. Date of Injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred After 1 Natural 2 Accident 5 Pending n 24 hours after death.

The Funeral Director: A pletely filled in by the funeral pletely filled in death. Investigation 1 ☐ Yes 2 ☐ No 6 Could not be determined 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide

Division of Vital Records, Hospital or Attending

To th. 6+1

State Registrar

completely

Medical

29a. Certifier

(Check only one)

29b. Signature and title of certifier

FATIMA HUSSEIN

29c. License number

1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29d. Date signed (Month, Day, Year)

30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 5625 ALLENTOWN RD. CAMP SPRINGS, MD. 20746

31. Date filed (Month, Day, Year) **Jan o 7 201**0

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State
Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ 345 Feller Marie Verna Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death Allegany WMHS- RMC Cumberland If Under 1 Year If Under 24 Hrs. Social Security Number 7. Age (In yrs. last birthday) **Funeral** 8. Date of Birth 9. Birthplace (State or Foreign Country) WV 1 🗆 M 2 🔾 🗗 Hours Min Month, Day Director 215-78-1491 80 Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location within 72 hours after death with the Maryland iral", or items 23a or 28a-f sho Examiner must be notified at 10d. Inside City Limits Director Allegany MD Cumberland 1 XYes 2 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 13105 Woodridge Lane 21502 USA 12. Was Decedent Ever in U.S. Armed Forces?
1 ☐ Yes 2 ☐ No If Yes, Give 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian þ 1 Never Married 2 Married Maryland 21215-0036 1 Yes 2 No Specify. 3 XWidowed 4 Divorced "natural" Completed white Year or Dates the Medical 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) I Hygiene. Elementary/Seconday (0-12) College (1-4 or 5+) 12 homemaker own home Be permit. Page 1 and 2 should be filed Department of Health and Mental Hy Important: If item 27 is marked oth any Injury or other traumatic event 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Garrett McDonald Mary McDonald 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)
11819 Bay Berry Avenue Cumberland MD 21502 Cheryl Porter daughte Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of 1 X Burial 2 Cremation 3 Removal from State Restlawn Memorial Gardens 12/29/2009 MD LaVale 4 ☐ Donation 5 ☐ Other (Specify) Signature of Lineral Servi / Lice see 22. Name and Address of Facility Funeral Home, PA 108 Virginia Avenue: Cumberland, MD 21502 23a Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final SYNDROME Physician SEPSIS EIGHT ITOUR disease or condition Medical resulting in death) Due to (or as a consequence of) Examiner SECONDANT PERITONITIS EIGHT HOURS Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury that initiated events Examine Dualto (or as a consequence of): STRTEEN / HOURS SIGMOID PERFURATED DIVERTICULUM executed attending physician and burial-trar Due to (or as a consequence of) resulting in death) Last Physician/Medical To the Hospital or Attending Physician: The law requires that the death certificate be within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physicis Division of Vital Records, P.O. Box 68760 as the IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death nse 23b. Was decedent pregnant 23d. Date of delivery 3 Cther (specify) in the past 12 months?
1 Yes 2 No sate has been signed by the atte page 2 should be detached for Month Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ DIVERTICULITIS Completed 2 No 3 Probably 4 Unknown NULMBNARY SMGE CHNONIC OBSTRUCTIVE 24a. Was an 24b. Were autopsy findings available prior to completion of cause of DISENSE autopsy ADULT ONSET DIABETES performe death? 2 No 25. Was case referred to medical Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 🗌 Yes 2 No မ 1 Nnpatient 2 ER/Outpatient 3 DOA 27. Manner of Death 28a. Date of injury (Month, Day, Year) Certificate: 28b. Time of 28c. Injury at 28d. Describe how injury occurred Natural 5 Pending work? 1 ☐ Yes 2 ☐ No 2 Accident
3 Suicide Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) completed filled in by 4 Homicide determined 29a. Certifier ဳ Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 🗆 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certifier 29c. License number Duc 44317 December 22, 30. Name and address of person who completed cause of death (Item 23a) (Type, Print).

JAMES R. MOEN, MD 1065 NATIONAL (TIGHNA: LAVME MMILMO)
21702

State Registrar 31. Date filed (Month, Day, Year)

JAN 0 7 2010

State of Maryland / Department of Health and Mental Hygiene Certificate of Death Decedent's Name (First, Middle, Last) 2. Date of Death **Physician** 11:37 A M 2009 December John William Farrell /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner St. Mary's 38175 Duke Heart Circle Avenue 5. Social Security Number 7. Age (In yrs, last birthday) If Under 1 Year | If Under 24 Hrs. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** Hours Months Min. 1 🕱 M 2 🗆 F Days 220-28-5856 Director 79 November 15,1930 Maryland Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits show r than "natural", or items 23a or 28a-f sho 1 Yes 2X No St. Mary's Maryland Avenue Direct death with the 10f. Zip Code 10e. Street and Number 10g. Citizen of What Country? 38175 Duke Heart Circle 20609 USA Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 14. Race - American Indian, 11. Marital Status Black, White, etc. Pages 1 and 2 should be filed within 72 hours after nent of Health and Mental Hygiene. nt: If item 27 is marked other than "natural", or ite 1 ⊠Yes 2 ☐ If Yes, Give Year or Dates: 1 Never Married 2 Married 2 □ No Baltimore, Maryland 21215-0036 1 ☐Yes 21 No Specify. Specify: White þ 3 ☐ Widowed 4 ☑ Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) State Highway Elementary/Secondary (0-12) College (1-4or 5+) Truck Driver Adminstration 12 traumatic event, 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Noble Farell 2 Unknown Marv 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) MD permit. Pages 1 and 2 s
Department of Health a
Important: If item 27 is
any Injury or other trau John Lee Farrell, Sr. 25502 Budds Creek Road, P.O. Son Box 361 Chaptico, 20621 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State December 31, 1 ☑ Burial 2 ☐ Cremation 3 Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Charles Memorial Gardens Leonardtown, Maryland 2009 21. Signature of Funeral Service Licenses 22. Name and Address of Facility Mattingley-Gardiner Funeral Home P.O. Box 270 Leonardtown, MD 20 Mhae Approximate Interval Between Onset and Death 23a. Parth. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) **Physician** - Oronzva /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examine law requires that the death certificate be executed burial-trar Du lo (or as a consequence of): P.O. Box 68760, attending physician for use as the buria Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year Pregnant at time of death 5 Other (specify) signed by the a d be detached f 9 I Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, Completed by 1 ☐ Yes 2 2 No 3 ☐ Probably 4 ☐ Unknown nis certificate has been s director, page 2 should 24b. Were autopsy findings available prior to completion of cause of death?

1 □Yes 2 □No 24a. Was an autopsy performed? 1 Yes 2 No 2 🗆 No 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home Statesidence 6 Other (Specify) Hospital: 1 Yes 2 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To completely filled in by the funeral 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28c. Injury at Work? 28d. Describe how injury occurred After To the Hospital or Attending within 24 hours after death.

To the Funeral Director: After 5 ☐ Pending investigation Natural 1 ☐ Yes 2 ☐ No 2 Accident 3 Suicide 6 Could not be determined 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide Medical 29a. Certifier Sertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only 29d. Date signed (Month, Day, Year) 29b. Signature and the of certifier 29c. License number December 23, 2009 D0000506 eme 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Leon W. Berube, M.D. 28170 Old Village Mechancisville, MD 20659 _Road 31. Date filed (Month, Day, Year) 32. Registrar's Signature Registrar

DHMH 17 Rev 1/2001

			State of Maryland / Dep	artment of Health and I	Mental Hyg	iene
				rtificate of Death	T	cg. no.
	Physicia		1. Decedent's Name (First, Middle, Last)		2. Date of Deatl Month	Day Year
	Medic Examin		Helen Ann Ferguson 4a. Facility Name (if not institution, give street and number)	4b. City, Town, or Location of Death	Dec 18,	2009 1:30 P M
مر	LAGITITI	CI	3137 Laurel Avenue	Cheverly		Prince George's
	Funeral		5. Social Security Number 6. Sex 7. Age (In yrs. last birthday)	If Under 1 Year If Under 24 Hrs. Months Days Hours Min.	8. Date of Birth	Birthplace (State or Foreign
	Director		185-14-9031 1 M 2 X F 85 Yrs. Usual Residence of Decedent	Willis Days Flours Will.	Apr 4,	Year) 1924 Nanty-Glo, PA
	and show at	ō	10a. State 10b. County 10c. City, Town or L	ocation		10d. Inside City Limits
	Maryla 8a-f s tified	Director	MD Prince George's Chev	erly		1X Yes 2 ☐ No
	a or 2 be no	۵	10e. Street and Number	10f, Zip Code	1	0g. Citizen of What Country?
	ns 23 must	Funeral	3137 Laurel Avenue	20785		USA
	r deat r iten iner r		11. Marital Status 1 □ Never Married 2 □ Married 12. Was Decedent Ever in U.S. Armed Forces? 1 □ Ves 2 ☒ No	Was Decedent of Hispanic Origin? (Sp. If Yes, specify Cuban, Mexican, Puerto	ecify Yes or No- Rican, etc.)	14. Race - American Indian, Black, White, etc.
920	s after 'al", o Exam	d by	3 ☒ Widowed 4 ☐ Divorced 1 ☐ Yes 2 ☒ No If Yes, Give Year or Dates,	1 ☐ Yes 2X No Specify:		Specify: White
<u>Ö</u>	hour	Completed	15. Decedent's Education 16a. Dece	dent's Usual Occupation		16b. Kind of Business Industry
7	nin 72 ne. than e	mo	Elementary/Seconday (0-12) College (1-4 or 5+)	kind of work done during most of work OO NOT use retired)	ing	
7	d with	Be C	12 17. Father's Name (First, Middle, Last)	Homemaker		Own Home
au	be file ental I ked o c eve	To E	Louis Sabo		e <i>(First, Middle, M</i> th Kashcl	,
ary	nould ind M s mar umat		19a. Informant's Name/Relationship (Type, Print) 19b. Mail	ing Address (Street and Number or Run		
Ξ̈́	nd 2 sh ealth a n 27 is er tra			Laurel Ave, Cheve		
Baltimore, Maryland 21215-0036	e 1 ar of He If iten		20a. Method of Disposition 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State 20b. Place of Disposerery, cre	osition (Name of matory or other place)	Date 2	20c. Location - City or Town, State
Ē	t. Pag tment tant: jury o		4 Donation 5 Other (Specify) Cheltenham	Veterans Cemetery 12,	/30/09 (Cheltenham, Maryland
Ba	permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mertall Hyglene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.			2. Name and Address of Facility	10 P A	4739 Baltimore Avenue Hyattsville, MD 20781
			23a. Part 1. Enter the disease, or complications that caused the death. Do not en			
	nysician/		shock, or heart failure. List only one cause on each line. Immediate Cause (Final			Interval Between Onset and Death
	Medical		resulting in death) a. Colonially Aftery Due to (or as a consequence of):	DISCUSC		
	Examiner	<u>.</u>	Sequentially list conditions, b. Atherosclerosis			
	sit sit	nine	if any, leading to immediate cause. Enter Underlying Cause (Disease or linjury Hypertension			
	xecute n and al-tran	Examiner	that initiated events resulting in death) Last C. Due to (or as a consequence of):			
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9/8	ifficate ng phy as the	Med	IF FEMALE:			
Box 687	h cert tendir r use	ian/I	23b. Was decedent pregnant 23c. If yes, outcome of pregnancy	☐ Ectopic pregnancy		23d. Date of delivery
9	e deat the at hed fo	Physician/Me	1 ☐ Yes 2 ☐ No 4 ☐ Pregnant at time of death 5 ☐ 9 ☐ Unknown	Other (specify)		Month Day Year
7. O	hat the ed by detac	y Ph	Part II. Other significant conditions contributing to death but not resulting in the	underlying cause given in Part I.	23e. Did toba	acco use contribute to the cause of death?
8,	ires the signer of the signer	d by	Chronic obstructive pulmonary disea		1 □ Ye	s 2 □ No 3 □ Probably 4🛣 Unknown
of Vital Records,	w requ	Completed	Breast cancer		24a. Was an	
ခို	The fan ate ha	luo	Osteoarthritis		autopsy perform	ned? death?
e	ilan; ertifica etor, p		25. Was case referred to medical	26. Place of Death (Check		£ 10 2 1 10
5	hysic this ce al dire	은	1 ☐ Yes 2 🔀 No Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatie		me 5X Resider	nce 6 Other (Specify)
0	Jing F J. After 1 funera	Certificate:	27. Manner of Death 1 ☒ Natural 5 ☐ Pending 28a. Date of injury (Month, Day, Year) 28b. Time of injury	work?	28d. Describe hov	v injury occurred
SIOIS	Attend deat ctor: y the	ıţį:	2 ☐ Accident Investigation 3 ☐ Suicide 6 ☐ Could not be 4 ☐ Homeide 28e. Place of Injury - At home, farm, st	M 1 Yes 2 No	28f Location /Stre	eet and Number or Rural Route Number,
Division	al or / s after il Dire		4 \square Homicide determined 28e. Place of injury - At nome, farm, so building, etc. (Specify)	,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,	City or Town,	
	To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. Within 24 hours after death. Within 24 hours after death. Completed by the attending physician and completed filled in by the funeral director, page 2 should be detached for use as the burial-transit	Medical	29a. Certifier 1 X Certifying Physician: To the best of my knowledge, death (Check 2 Medical Examiner: On the basis of examination and/or invest	occured at the time, date and place, an	d due to the cause	e(s) and manner as stated.
	the F thin 24 the F mplet	_ (only one) 3 Certifying Nurse Practioner: To the best of my knowledge,	death occurred at the time, date and place	e, and due to the c	ause(s) and manner as stated.
	5 .≱ 6 8		29b. Signature and title of certifier	29c. License number D0057375	29	dd. Date signed (Month, Day, Year) $12/21/09$
	10		30. Name and address of person who completed cause of death (Item 23a) (Type,			
2	12		Izzat Chalabi 8116 Good Luck Rd,	,	MD 2070	6
	Stat	е	31. Date filed (Month, Day Year) DEC 2 3 2009 August 1989 1982 1982 1983			
Т	Registra	r	THE POLICE CHANGE DO.			

DHMH 17 Rev 7/2009

			For	Sta	ate of	Maryla				alth and M					
			1 - State Registrar				Ce	rtificate	of De	eath		Reg. No.	<u> 2009</u>	42	6 8
L	Physici	an	1. Decedent's Name (First, Midd	. ,							2. Date of Dea Month	Day	Year		of Death
-	/Medic	al	John Robert Fre	•							12/15/2			2:05	P ^M
	Examin	er	4a. Facility Name (If not institution				0			cation of Death			County of Death	1	
	Funeral		11500 Coastal H 5. Social Security Number	6. Sex			9 s. last birthday)	Ocean	Year If	Under 24 Hrs.	8. Date of Birt	h			e o <i>r Foreign</i>
и	Director		183-42-0828	1 🗓 M 2	2 🗆 F	57	Yrs.	Months D	Days H	Hours Min.	(Month, Day 12/25/1	951	PA_	intry)	
	w		Usual Residence of Decedent 10a, State 10b, County	,		10c. C	ity, Town or Lo	cation						10d. Inside	City Limits
	Maryti f sho	Ď											ĺ		s 2 No
	r 28a	Director	MD Worce 10e. Street and Number	ster		1 000	an Cit	10f. Zip Co	ode			10g. Citiz	zen of What Cou	intry?	
	th with		11500 Coastal H	lighway	uni	t 1209)	21842	2		ı	JSA			
	ems	Funeral	11. Marital Status	12. W		ent Ever in U	J.S. 13.	Was Deceden	t of Hispa	anic Origin? (Spe Mexican, Puerto	ecify Yes or No-		4. Race - Amer Black, White		
36	s afte	by Fi	1 ☐ Never Married — Mar 3 ☐ Widowed 4 ☐ Divorced		∐Yes 2 Yes, Give	-		1 □Yes 2.□		Specify:	,		SpecifyWhit		
21215-0036	filed within 72 hours after death with the Maryland Hygiene Uther than "natural", or items 23a or 28a-f show ent, the Medical Evanimer must be notified at	ted t		nt's Education	ear or Dat	es:	16a. Dece	dent's Usual C	Occupation	n			id of Business/li		
212	hin 72 3. an "na Medik	plet	(Specify only highe Elementary/Secondary (0-12)	est grade com	pleted) ollege (1-4	or 5+)	(Give	kind of work of DO NOT use i	done durin	ng most of worki	ng			,	
	ed witl ygiene er the	Completed	12		onege (1-4		53.1	Ste	ward			Re	stauran	t / B	ar
Maryland	<u> </u>	Be	17. Father's Name (First, Middle,	Last)						. Mother's Name					
3	2 should and Mer Is marke aumatic	ဥ	Allen Frey	· · · · · · · · · · · · · · · · · · ·			101 44 35			rtrude					
<u>a</u>	d 2 sh ith an 27 Is r traur	5 9	19a. Informant's Name/Relations Connie Frey (w		rint)		1			Number or Rura					1000
d)	es 1 and 2 should b of Health and Ment f item 27 Is marked r other traumatic e		20a. Method of Disposition	rife)		20b.	Place of Dispo cemetery, crer			y Ocean	ate		ation - City or T		1209
altimore,	permit. Pages 1 Department of H Important: If ite any Injury or ot		1 ☐ Burial 24☐ Cremation 4 ☐ Donation 5 ☐ Other (5		al from St	ate _	cemetery, crer e Henl			12/16	/2009 H	'rank	ford, D	F	
ati	partin porta y Inju		21. Signature of uneral Service			Jour				f FacilityThe					
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			23a. Part 1. Enter the disease, or shock, or heart failure. List	r complication only one cau	s that cau	sed the dea h li	th. Do not ent	er the mode o	of dying, so	uch as cardiac c	or respiratory ar	rest,		Approxim Interval E	letween
	Physician	1	Immediate Cause (Final disease or condition	a.	CHF	0								Onset an	d Death
-	/Medical Examiner		resulting in death)		Due to (or	as a conse	quence of):								
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	cuted id ansit	Examin	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (pisease or injury that initiated events	S .									-		
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8760,	ficate be executed physician and s the burial-transit	dical		d											
Ö	ding p	Mec	IF FEMALE:	220 lf	voe outce	me of pregn	anau								
Box	law requires that the death certific as been signed by the attending p 2 should be detached for use as	Physician/Me	23b. Was decedent pregnant in the past 12 months?	1	Live bir	th 2□Fet ntattime of	aldeath 3 🛭	Ectopic preg				2	3d. Date of deliver Month	very Day	Year
o.	the d	Jysi	1 ☐ Yes 2 ☐ No 9 ☐ Unknown		Unknov		1								
ν, σ.	w requires that the de been signed by the should be detached		Part II. Other significant condition		ing to dea	th but not res	sulting in the u	nderlying caus	se given in	Part I.	23e. Did to	bacco us	se contribute to	the cause o	f death?
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r E	s certificate has tirector, page 2 s	Con	1								perfor 1 □ Yes	med? 2 X No	death?	2 🗆 No	
<u> </u>	certifi ector,	Be	25. Was case referred to medica examiner?	l Hospita	al•	Gi ^r				. Place of Death	(Check onl or	ne)			
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בֿ	To the Hospital or Attending Physician: The Is within 24 hours after death. To the Funeral Director: After this certificate he completely filled in by the funeral director, page:	Certification: To	4 🗆 Hornicide		bulluling	, etc. <i>(Sp</i> ec	ny)				City or Tow	n, State)			
	10spi 4 hou Tuner ely fill		Check only 2 Medical	ng Physician Examiner: C	: To the b	est of my kn is of examin	owledge, deatl	n occurred at vestigation, in	the time, o	date and place, on, death occurr	and due to the	cause(s)	and manner as	stated. to the cause	e(s)
	the thin 2 the mplet	Medical	one) 29b. Signature and title of certifie	aı	nd manne	r stated.									
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		ŀ	30. Name and address of person	who complet	ed cause	of death (Ite	m 23a) (Type	Print)	-					-	
	घ 5		Angela Gibbs,	MD	104	45 0	14 Ocen	n Cita	Bl	mber 66169 vd. B	erlini	MD	2181	1	
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	Registra	ir	DEC 16	2009	Der	wa	p. 90	aver							

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Reg. No. 2009 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2 Date of Death 3. Time of Death **Physician** JOHN PAUL GOODRICK 11211129-09 5:45A /Medical 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Death Examiner 9250 POORHOUSE ROAD PORT TOBACCO CHARLES 5. Social Security Number If Under 1 Year | If Under 24 Hrs. 8. Date of Birth Month, Day, Year 9-13-1928 6 Sex 7. Age (In vrs. last birthday) 9. Birthplace (State or Foreign 1 XM 2 □ F Months Days Hours Min WASH., D.C. 578-28-4818 81 Usual Residence of Decedent 10a State 10h. County 10c. City. Town or Location 10d. Inside City Limits MD. CHARLES PORT TOBACCO 1 □Yes 2 No Director 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 9250 POORHOUSE ROAD 20677 U.S.A. Funeral 12. Was Decedent Ever in U.S.
Armed Forces?

1 ∑Yes 2 □ No USAF
If Yes, Give 1950-70 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 1 ☐ Never Married 2 ☐ Married 1 ☐ Yes 2 ☐ No Specify: 2 Specify: WHITE 3 ₩ Widowed 4 □ Divorced Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) RET. TECH. SGT. U.S.AIR FORCE 9th 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be LEWIS GOODRICK PEARL JONES ၉ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) MARIE PICKETT-DAUGHTER 9250 POORHOUSE RD. PORT TOBACCO, MD. 20677 20a. Method of Disposition 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 1 ☐ Burial 2 🄀 Cremation 3 Removal from 4 ☐ Donation 5 ☐ Other (Specify) METROPOLITAN CREMATORY 12-31-09ALEX., VA. 22. Name and Address of Facility M00479 RAYMOND FUNERAL SERVICE, P.A. LA PLATA, MD. 20646 23a. Part 1. Enter the disease, or complications that caused the death. shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Do not enter the mode of dying, such as cardiac or respiratory arrest, Immediate Cause (Final TS 21 -OV 6 disease or condition resulting in death) Due to (or as a consequence of): Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Due to (or as a consequence of) IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? Day Month Year 5 Other (specify) 1 ☐ Yes 2 ☐ No. 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed 1 ☐ Yes 2 Z No 1 ☐Yes 2 ☐No 25. Was case referred to medical examiner? 26. Place of Death (Check only one Other: 4 Nursing Home 1 Yes 2 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 5 Residence 6 Other (Specify) 27. Manner of Death 28b. Time of 28d. Describe how injury occurred

attending physician and for use as the burial-transit Box 68760. P.O. been signed by the should be detached Division of Vital Records. cate has by certificate To the Hospital or Attending Physician: this certifical director, After thi funeral o

Funeral

Director

28a-f show

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23a death v

or items

2 should be filed within 72 hours after on and Mental Hygiene. Is marked other than "natural", or iter

permit. Pages 1 and 2 st Department of Health an Important: If item 27 is r any injury or other traur

Physician

/Medical

Examiner

Baltimore, Maryland 21215-0036

traumatic event, the Medical Expression must be notified at

Examine Physician/Medical þ Completed Be Certification: To

Medical

State Registrar

one)

within 24 hours after death.

To the Funeral Director: A completely filled in by the fu death.

28a. Date of Injury (Month, Day, Year) 28c. Injury at Work? 5 ☐ Pending investigation 14 Natural 2 Accident 1 ☐ Yes 2 ☐ No 6 ☐ Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 ☐ Homicide 29a. Certifier Lertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Leading Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only

44

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

31. Date filed (Month, Day, Year)

29b. Signature and title of certifier

. Registrar's Signature

29c. License number

29d. Date signed (Month, Day, Year)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 2 0 0 Certificate of Death Reg. No 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month December WILLIAM GRIMES JR. 4:00 A^{M} CHARLES Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death Frederick Frederick Memorial Hospital Frederick 5. Social Security Number 7. Age (*In yr*s. **74** last birthday If Under 1 Year If Under 24 Hrs 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** 214-32-4471 1 🛛 M 2 🗆 F Davs Hours Min. Septh, Day (Sear) 1939 Mary land Director Usual Residence of Decedent Show 10b. County 10c. City, Town or Location 10d. Inside City Limits "natural", or items 23a or 28a-f sho idical Examiner must be notified at Director Frederick Maryland Frederick 1 Yes 2 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 21701 Funeral 5928 Quinn Road U.S.A. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 11. Marital Status 14. Race - American Indian. Armed Forces Completed by 1 Never Married 2 X Married 1 Yes 72 hours after Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify: Specify: White 3 Divorced 4 Divorced Year or Dates the Medical Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) Health and Mental Hygiene. Elementary/Seconday (0-12) College (1-4 or 5+) Nursing Home Maintenance Supervisor 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname)
Mildred Virginia Frye Charles William Grimes, Sr. 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 5928 Quinn Road, Frederick, MD 21701 Barbara V. Grimes, wife Page 1 and 2 item 20b. Place of Disposition (Name of cemetery, crematory or other place)

Mount Olivet Cemetery Dec. 31, 20a. Method of Disposition 20c. Location - City or Town, State permit. Page 1 Department of Important: If it any injury or o ō 1 ⚠ Burial 2 ☐ Cremation 3 ☐ Removal from State 2D09 Frederick, MD 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Lica. 2Keeney dand Basford PA Funeral Home 106 East Church St., Frederick, MD 21701 M00255 23a. Part 1. Enter the disease, or complication that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate shock, or heart failure. List only one cause Interval Between Onset and Death Immediate Cause (Final Physician/ disease or condition resulting in death) Medical Due to (or as a consequence of) Examiner Sequentially list conditions. Examine if any, leading to immediate cause. Enter underlying Cause (Disease or iinjury Due to (or as a consequence of) Hospital or Attending Physician: The law requires that the death certificate be execute attending physician and for use as the burial-tran that initiated events Due to (or as a consequence of): resulting in death) Last Physician/Medical Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? Dav Pregnant at time of death 5 Other (specify) 2 No ed by the a detached f 9 Unknown 9 Unknown Division of Vital Records, P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. sate has been signed page 2 should be det 23e. Did tobacco use contribute to the cause of death? þ 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 Yes 2 No 24a. Was an autopsy within 24 hours after death.

To the Funeral Director: After this certific completed filled in by the funeral director, Be 25. Was case referred to medical 26. Place of Death (Check only one) Hospital: 2 1 No 1 Yes မ 1 Inpatient 2 I ER/Outpatient 3 I DOA 4 Nursing Home 5 Residence 6 Other (Specify) 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at work? 1 □ Yes 2 □ No Certificate: 28d. Describe how injury occurred 1 🛂 Natural injury 5 Pending 2 Accident
3 Suicide
4 Homicide Investigation Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, determined City or Town, State) Medical Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
3 Certifying-Nurse Practioner: To the basis of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

10

State Registrar 29b. Signature and title of certifier

mpleted cause of death (Item 23a) (Type, Print)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death DECEMBER 24 2009 EDWIN GULLETT WILLIAM 12:30pM 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death 226 Royston Shores Rd. Chestertown Oueen Anne's If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth Months | Days | Hours | Min. | Mar 20, 5. Social Security Number 6. Sex 9. Birthplace (State or Foreign 7. Age (In vrs. last birthdav) 1 ☑ M 2 □ F Months 1933 New Jersey 203-26-9770 76 Usual Residence of Decedent 10a. State 10c. City. Town or Location 10d. inside City Limits 1 ☐ Yes 2 ☐ No MD Queen Anne's Chestertown 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 226 Royston Shores Rd. 21620 U.S.A. 12. Was Decedent Ever in U.S. Armed Forces? 11. Maritai Status Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 1 ☐ Never Married 2 ☑ Married Cares 2 No if Yes, Give Year or Dates: Korea 1 ☐ Yes 2 No Specify White Specify: 3 Widowed 4 Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Electrical Contractor Self-employed 12 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) William Edwin Gullett Margaret Fernwalt 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Patricia Gullett (wife) 226 Royston Shores Rd. Chestertown, MD 20a. Method of Disposition 20c. Location - City or Town, State Date Place of Disposition (Name of cemetery, crematory or other place) 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State Kent Cremation 12/28/09 4 Donation 5 ☐ Other (Specify) Smyrna, DE. ^{22. Name and Address of Facility}
Galena Funeral Home of Stephen L Schaech
118 West Cross St. Galena, MD. 21635 21. Signume of Funeral Se vice License M00510 23a. Part / Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death immediate Cruse (Final disease or condition resulting in death) (moon Due to (or as a consequence of) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Dus to for as a consequence of resulting in death) Last Due to (or as a consequence of) IF FEMALE: 23c. if yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetai death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? Month Year Day 5 ☐ Other (specify) 1 ☐ Yes 2 ☐ No. 9 Unknown 23e. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy perform 2 No 1 ☐ Yes 1 ☐ Yes 26. Place of Death (Check only ne) Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA

Physician /Medical Examiner Examine

Physician

Examiner

Funeral

Director

show

death with

72 hours after

Baltimore, Maryland 21215-0036

Director

Funeral

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d other than "natural", or items 23a or 28a-f show event, it a Modical Examinar must be notified at

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permit. Pages 1 and 2 should be file Department of Health and Mental Hy Important: If Item 27 Is marked other any injury or other traumatic event.

/Medical

Physician: The law requires that the death certificate be execute physician and s the burial-trans attending p signed by t be detach has e 2 s page certificate

Physician/Medical

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Be

Medical Certification: To

29a. Certifier (Check only one)

Box 68760,

P.O.

Records,

Division of Vital

After this certific funeral director, To the Hospital or Attending within 24 hours after death.

To the Funeral Director: A completely filled in by the fu death.

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Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part Completed 25. Was case referre medical examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 28a. Date of Injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28d. Describe how injury occurred 1 Natural 5 Pending investigation 1 □ Yes 2 🗆 No 2 Accident 3 Suicide 6 ☐ Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined

29b. Signature and title of certifier

1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29d. Date signed (Month, Day, Year)

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

King, Matthew J. M.D. 120 Speer Rd. Chestertown, MD.

31. Date filed (Month, Day, Year)

JAN 0 7 2010

32. Registrar's Signature

State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death Reg. No. 2 1 1 9 1. Decedent's Name (First, Middle, Last) 2. Date of Death **Physician** December 28 2009 Josephine Natalie Gagliano /Medical 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Death Examiner Elkton Union Hospital Cecil 5. Social Security Number 7. Age (In vrs. last birthday) Birthplace (State or Foreign Country) **Funeral** Months Days 1 □ M 2 🖾 F 187-28-8900 73 **Director** Usual Residence of Decedent 10a. State 10b. County 10c. City Town or Location 10d. Inside City Limits 28a-f show event, the Medical Examiner must be notified at Director 1 Yes 2 No MD Kent Galena 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 23a or 105 Cedarwood 21635 U.S.A. Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☑No If Yes, Give Year or Dates: Items 11. Marital Status Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 72 hours after 1 ☐ Never Married 2 ☑ Married Baltimore, Maryland 21215-0036 "natural", or 1 ☐ Yes 2√2 No Specify. White þ Specify: 3 Widowed 4 Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) than " Elementary/Secondary (0-12) College (1-4or 5+) Packer & Shipper Pharmacutical 12 permit. Pages 1 and 2 should be filed I Department of Health and Mental Hygic Important: If Item 27 is marked other I any Injury or other traumatic event, In 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Roy Sassany ပ Dina Mosconi 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Paul F. Gagliano 105 Cedarwood Dr. Galena, (husband) MD. 21635 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Cremation 3 ☐ Re 4 ☐ Donation 5 ☐ Other (Specify) 3 Removal from State Galena Cemetery 1/2/2010 Galena, MD. ensee re of Funer 5 22. Name and Address of Facility
Galena Funeral Home of Stephen L Schaech M00510 118 West Cross St. Galena, MD. 21635 23a. Part 1 Inter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or reart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Quse (Final **Physician** Kes piratory disease or condition resulting in death) Medical Due to (or as a consequence of): Examiner 13 lateral Sequentially list conditions, Examiner cause. Enter Underlying Cause (Disease or injury that initiated events physician and s the burial-trans resulting in death) Last Due to (or as a consequence of): P.O. Box 68760 Physician/Medical attending p IF FEMALE: 23c. If yes, outcome of pregnancy 23b. Was decedent pregnant 23d. Date of delivery Live birth 2 Fetal death
Pregnant at time of death in the past 12 months?

1 Yes 2 No
9 Unknown 3 Ectopic pregnancy Day Year Month 5 Other (specify) the signed t Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Records, Completed by 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown mehoma Were autopsy findings available prior to completion of cause of death? 24a. Was an cate has by page 2 s autopsy The performe certificate Division of Vital 2 No 1 ☐ Yes Hospital or Attending Physician: After this certification funeral director, p 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? 1 Yes 2 No Other: 4 Nursing Home 5 Residence 6 Other (Specify) Medical Certification: To 1 Minpatient 2 ☐ ER/Outpatient 3 ☐ DOA 28a. Date of Injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural 2 ☐ Accident 5 Pending n 24 hours after death.

le Funeral Director: A
bletely filled in by the fu death. investigation 1 ☐ Yes 2 ☐ No 6 ☐ Could not be 3 Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide

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State Registrar

29a. Certifier

(Check only one)

29b. Signature and title of certifier

31. Date filed (Month, Day, Year,

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32. Registrar's Signat

Street

30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 6

1 🖹 CertifyIng Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29c. License number D69048

Elkton MD

29d. Date signed (Month, Day, Year)

12 28/2005

			For State State Registrar	te of Mary		partment of l Certificate of			ene g. No. 2 A A A	1,2623
	Dhusisi		Decedent's Name (First, Middle, Last)					2. Date of Death Month	Day Year	3. Time of Death
	Physicia /Medic		MICHAEL GA					DEC 15		4:17 A ^M
	Examin	er	4a. Facility Name (If not Institution, give street a NATIONAL NAVAL MED		JTFR		or Location of Death	1	4c. County of Death MONTGO	MERY
wy of	Funeral		5. Social Security Number 6. Sex		yrs. last birthd		If Under 24 Hrs. Hours Min.	8. Date of Birth	9 Birthr	place (State or Foreign
	Director		279 10 3330	∐ F	89 Yrs	S. World S Buys	, louid with	Oct. 29,	1920 PA	
	land ow		Usual Residence of Decedent 10a. State 10b. County	100	c. City, Town or	Location			1	0d. Inside City Limits
	Mary a-f sh	ctor	VA Fairfax	1	McLean					1 □Yes 2 ĀNo
	or 28	Dire	10e. Street and Number			10f. Zip Code		10	g. Citizen of What Cour	ntry?
	s 23a	eral	1433 Fern Oak Ct.	- Deceded Time	in 11 C	221		pocify/Voe or No-	USA 14. Race - Americ	ean Indian
36	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hyglene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show amy injury or other traumatic event, the Medical Exerciting I must be mutilial at once.	by Funeral Director	1 Never Married 2 Married 1 If Y	s Decedent Ever ned Forces? Yes 2 ☐ No es, Give ar or Dates:	1942-	 Was Decedent of If Yes, specify Cul 1 ☐ Yes 2 No 		o Rican, etc.)	Black, White,	etc.
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Maryland	Aental Aental rked o	To Be	Theodore Gavula				Anna Kad	czmarczyk		
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mor	Pages ment of I ant: If ite ury or o		1 Burial 2 ☐ Cremation 3 ☐ Remove 4 ☐ Donation 5 ☐ Other (Specify)	BI from State I		crematory or other pla on Nationa		18/10	Arlington,	VA
Baltimore,	permit. Departn Importa any Inju		21. Signature of Funeral Service Licensee			22. Name and Add		lson Blv	d. Arlingto	on, VA 22203
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	/Medical Examiner		resulting in death)	Due to (or as a co	nsequence of):					
		Jer	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying	Due to (or as a co	nsequence of):					
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,0928	icate be executed physician and the burial-transit	E E	resulting in death) Last	Due to (or as a co	nsequence of):	:				
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rds, P.	law requires that the de as been signed by the 2 should be detached	þ	Part II. Other significant conditions contributions	ng to death but no	ot resulting in th	ne underlying cause g	iven in Part I.		bacco use contribute to es 2 1 No 3 Pro	
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of Vital	Physician: The this certificate ral director, pag	Be (25. Was case referred to medical examiner?	al:		10	thor	ath (Check only on		
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ion	Attending Phire death. ector: After thi	atior	1 Natural 5 Pending 2 Accident investigation	(Month, Day, Ye	ear) Inju		ork? ⊒Yes 2.⊡No			
Division	P # # E	Certification: To	3 Suicide 6 Could not be determined 286	e. Place of Injury - building, etc. (5		, street, factory, office		28f. Location (Si City or Town	treet and Number or Rui n, State)	ral Route Number,
	To the Hospital or Atten within 24 hours after deatl To the Funeral Director: completely filled in by the	Medical C	29a. Certifler (Check only one) 15. Certiflying Physician 2 Medical Examiner: Care	To the best of months the basis of example the basis of example the basis of example the basis of the basis o	amination and/	death occurred at the or investigation, in m	time, date and place opinion, death occ	e, and due to the ourred at the time, o	cause(s) and manner as late and place, and due	stated. to the cause(s)
-2011	To the comp	M	29b. Signature and title of certifier			29c. Lice	nse number		29d. Date signed (Month	, Day, Year)
			The state of the				01018528	(MI)	ELEMBER!	17, 2009
R	25		30. Name and address of person who complet		n (Item 23a) (Ty USN	ype, Print)			MEDICAL CEN	TER
	Sta	ite	21 Date filed (Month Day Year)	32 Registrar's	Signature	1	BETHESD	A MD ZU	889-5600	
	Regist		DEC 2 2 2009 Sene	a > B.	gare					

DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. amend #19a&20th Per Marviand 9 Department of Health and Mental Hygiene for State of Maryland / Department of Health Registrar 12–28–09 Amend #'s1.19a. Per Phys. & Infinite rijficate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Neal Oliver Grady 12/14/2009 \mathbf{P}^{M} NEIL OLIVER GRADY Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner 2906 WEST AVE. DISTRICT HEIGHTS PRINCE GEORGE'S Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** 1 ፟ M 2 □ F Months Days Hours Min. (Month, Day, Year) 1 1 2 9 7 1 9 3 1 Director 230-31-1975 78 Pinehurst, Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director 1X Yes 2 ☐ No Maryland Prince George's Forestville 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 2906 West Ave. 20747 United States 11 Marital Status 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-14 Bace - American Indian Armed Forces If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Black, White, etc. þ 1 Never Married 2 Married X Yes 2 No Baltimore, Maryland 21215-0036 1 ☐ Yes 2 K No Specify: Specify: Black If Yes, Give Completed 3 X Widowed 4 Divorced Year or Dates 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) Soldier/ Security Officer Government Be 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) ပ Aggie Dowd injury or other traumatic Eddie Grady 19a. Informant's Name/Relationship (Type, Print)
Ronald P. Wilson /step-son 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Page 1 and 2 sh Department of Health ar Important: If item 27 is any injury or other trau Ronald Paul 2906 West District Heights, Maryland 20747 Ave, 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Page 1 1/08/2010 1 🔀 Burial 2 🗆 Cremation 3 🗆 Removal from State 4 Donation 5 Other (Specify) Maryland Veterans 12/28/2009 Cheltenham, Maryland 21. Signature of Funeral Service Lice Service 22. Name and Address of Facility Pope Funeral Homes, P.A. 401053 5538 Marlboro Pike Forestville, Maryland 20747 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death MONTH Immediate Cause (Final Physician/ CARCINOMA OF THE LUNG disease or condition resulting in death) Medical Due to (or as a consequence of): Examiner Sequentially list conditions. Examine if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Due to (or as a consequence of): the Hospital or Attending Physician: The law requires that the death certificate be executed and that initiated events resulting in death) Last Due to (or as a consequence of) attending physician a for use as the burial-Physician/Medical Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ in the past 12 months? Month Year 4 Pregnant at time of death 9 Unknown 1 Yes 2 9 Unknown 2 🗌 No Division of Vital Records, P.O. þ Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. this certificate has been signed I al director, page 2 should be det 23e. Did tobacco use contribute to the cause of death? þ 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of 24a. Was an autopsy performed? death? 1 Yes 2 No Yes 2X No Be 25. Was case referred to medica 26. Place of Death (Check only one) examiner? Hospital Other: 4 \square Nursing Home 5 $\overline{\mathbf{X}}$ Residence 6 \square Other (Specify) 2 🔀 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA ည To the Hospital or Attending Phy within 24 hours after death.

To the Funeral Director; After this completed filled in by the funeral or 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred Certificate: 1 🔀 Natural 2 🗋 Accident 3 🔲 Suicide 4 🗌 Homicide 5 Pending work? 1 ☐ Yes 2 ☐ No Investigation 6 Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) Place of Injury - At home, farm, street, factory, office building, etc. (Specify) Medical 1 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated (Check only one 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

State Registrar 29b. Signature and title of certifier

DEC 2 3 2009

Craig

DHMH 17 Rev 7/2009

WD

32. Registar's Sig

30. Name and address of person who completed cause of death (Item 23a) (Type, Print) M.D.

Jeschke,

29c. License numbe

D0026010

4225 Altamont Place Suite 201 White Plains, MD 20695

29d. Date signed (Month, Day, Year)

12/18/2009

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

			for State of State of Registrar	Maryland / Dep Ce	ertificate of D			giene Reg. No. (2009	42625
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	Physicia Medic		Quretta Inez Gater				Decembe	7 11	2009	2020 M
مر	Examin	er	4a. Facility Name (if not institution, give street and number 6501 Parkwood Street	per)	4b. City, Town, or	rer Hills			ounty of Death Prince G	eorge's
***************************************	Funeral		5. Social Security Number 6. Sex	7. Age (In yrs. last birthday)	If Under 1 Year	If Under 24 Hrs.	8. Date of Birt	h	9. Birtho	lace (State or Foreign
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	h the lagarda or 2	al Di	10e. Street and Number		10f. Zip Code			Ü	en of What Cour	
	ath wit	Funeral Director	6501 Parkwood Street 11. Marital Status 12. Was Deced	dent Ever in U.S. 13.	20784 Was Decedent of His	spanic Origin? (Spe	cify Yes or No-		ted Sta	
Maryland 21215-0036	should be filed within 72 hours after death with the Maryland hand Mental Hygene. 7 is marked other than "natural", or items 23a or 28a-f show raumatic event, the Medical Examiner must be notified at	ed by F	1 ☐ Never Married 2 🔀 Married 1 ☐ Never Married 2 ☐ Married 1 ☐ Yes 1 ☐ Yes 1 ☐ Yes, Give Year or Dat	2 🖾 No	. Was Decedent of His If Yes, specify Cubar 1 ☐ Yes 2 🏝 No		Rican, etc.)		Black, White, opecify: Black	etc.
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<u> </u>	uld be I Meni narke natic	1º	Allen Wright			Lest		hnsor		2.71
Z Z	2 sho Ith and 27 is r traun		19a. Informant's Name/Relationship (Type, Print) Laketia Gater/ Daughter		ling Address (Street a	nd Number or Rura Road, La			20785	iode)
re,	1 and of Hea item		20a. Method of Disposition	20b. Place of Disp			Date		ation - City or To	wn, State
Ĕ	Page ment c tant: If		1 🔀 Burial 2 □ Cremation 3 □ Removal from 4 □ Donation 5 □ Other (Specify)	Memor	armony ial Parl	19,	2009			Maryland
Baltimore,	permit. Page 1 and 2 should be f Department of Health and Menta Important: If item 27 is marked any injury or other traumatic e once.		21. a nature of Funeral Service licensee	1 11 1	22. Name and Addres				_	Inc. 20019
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Records,	law has e 2	Completed					24a. Was autoj perfo 1 Yes	osv	24b. Were auto prior to co death? 1 Yes	psy findings available mpletion of cause of
<u>e</u>	ician: The certificate rector, pag	BeC	25. Was case referred to medical examiner?			ace of Death (Check		2,20,10,		
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Division of Vital	or Atter after dea Director in by the	Certificate:	3 Suicide 6 Could not be 28e. Place	of Injury - At home, farm, s ng, etc. (Specify)	street, factory, office	***	28f. Location (\$ City or Tow		Number or Rura	Route Number,
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	To the within 7 To the comple	Š	only one) 3 Certifying Nurse Practioner: 29b. Signature and title of certifier		29c. License	number	e, and due to th	29d. Date	signed (Month,	Day, Year)
			Michael R. gald							17 2009
R	10		30. Name and address of person who completed caus Michael R. Grunwald, Jo	e of death (Item 23a) (Type has Hopkins H	lospital, 60	oo North v	Volfe SH	eet, B	altimore,	Maryland 21287
	Sta Registra		31. DEC 2 3 2009 Annu 32. R	egiorar's Sichature						

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last, 2. Date of Death Physician/ Lynn Monese Gallagher December 15 ay 2009 Year 7:13 a Medical Examiner 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Silver Spring Montgomery 12513 Farnell Drive Social Security Number 6. Sex If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) Jan. 5, 1941 **Funeral** 7. Age (In vrs. last birthdav) 9. Birthplace (State or Foreign 1 □ M 2 □ F Months Days Hours Country) Lexas Director 554-58-6371 68 Vrs Usual Residence of Decedent works 10a. State 10b County the Maryland ral", or items 23a or 28a-f shore Examiner must be notified at 10c. City, Town or Location Director 10d. Inside City Limits 1 Tes 2 No Maryland Montgomery Silver Spring 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral with 12513 Farnell Drive 20906 within 72 hours after death 12. Was Decedent Ever in U.S. 11 Marital Status 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. Armed Forces? Black, White, etc. þ 1 Never Married 2 Married Maryland 21215-0036 If Yes, Give Year or Dates. 1 ☐ Yes 2 H No Specify "natural" Completed 3 Widowed 4 Divorced White the Medical 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business Industry Elementary/Seconday (0-12) College (1-4 or 5+) Homemaker Own Home and Mental Hygie is marked other permit. Page 1 and 2 should be filed wi Department of Health and Mental Hygie Important: If item 27 is marked other any injury or other traumatic event. tt Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ဥ Edward Anson Ballard Geraldine Hanna 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Monese B. Weeks/Daughter 4618 Creek Shore Drive, Rockville, MD 20852 Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State 1 Burial 2 Cremation 3 Removal from State cemetery, crematory or other place)
Metropolitan Crematory 16, 4 Donation 5 Offer (Specify) Alexandria, Virginia 22 Name and Address of Facility Funeral Home Inc. 500 University Blvd. W., Silver Spring, MD 20901 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death years Immediate Cause (Final Ph sician/ Chronic Obstructive Pulmonary Disease disease or condition Medical resulting in death) Due to (or as a consequence of). [⊀]Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examine Due to (or as a consequence of): attending physician and for use as the burial-transit Cause (Disease or linjury that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical the Hospital or Attending Physician: The law requires that the death certificate be Division of Vital Records, P.O. Box 68760 IF FEMALE 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy 5 Other (specify) in the past 12 months? Day Year 4 ☐ Pregnant at time of death 9 ☐ Unknown be detached the 9 Unknown signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Completed 1 🗷 Yes 2 □ No 3 □ Probably 4 □ Unknown peene autopsy findings available prior to completion of cause of death? 24b. Were autopsy findings available 24a. Was an certificate has autopsy performed?

1 Yes 2 No 1 Yes 2 No 25. Was case referred to medical B B 26. Place of Death (Check only one) examiner? 1 Tes Other: ည 2 😾 No 1 Inpatient 2 I ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify, funeral 27. Manner of Death Certificate: 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred X Natural work? 5 Pending Accident
Suicide 2 🗌 No Investigation 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide determined 28f. Location (Street and Number or Rural Route Number City or Town, State) Medical

24 hours after death.

Funeral Director: After this within 2 To the F 2

> State Registrar

29a. Certifier

only one)

3 E

29b. Signature and title of certifier

31. Date filed (Month, Day, Year DEC 17

7 a 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Anurita Mendhiratta,MD 2401 Research Blvd. Suite 350, Rockville, MD 20850

1 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

[Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

D38262

29d. Date signed (Month. Day, Year)

December 16, 2009

Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Baltimore. Maryland 21215-0036

P.O. Box 68760. Division of Vital Records.

Thomas Mortan Cittings For June 1 Thomas A Thomas A Facility Reven (Front Auditation, post annex and names) Thomas A Facility Reven (Front Auditation, post annex and names) Thomas A Facility Reven (Front Auditation, post annex and names) Thomas A Facility Reven (Front Auditation, post annex and names) Thomas A Facility Reven (Front Auditation, post annex and names) Thomas A Facility Reven (Front Auditation, post annex and names) Thomas A Facility Reven (Front Auditation, post annex and names) Thomas A Facility Reven (Front Auditation, post annex and names) Thomas A Facility Reven (Front Auditation, post annex and names) Thomas A Facility Reven (Front Auditation, post annex and names) Thomas A Facility Reven (Front Auditation, post annex and names) Thomas A Facility Reven (Front Auditation, post annex and names) Thomas A Facility Reven (Front Auditation, post annex and names) Thomas A Facility Reven (Front Auditation, post annex and names) Thomas A Facility Reven (Front Auditation, post annex and names) Thomas A Facility Reven (Front Auditation, post annex and names) Thomas A Facility Reven (Front Auditation, post annex and names) Thomas A Facility Reven (Front Auditation, post annex and names) Thomas A Facility Reven (Front Auditation, post annex and names) Thomas A Facility Reven (Front Auditation, post annex and names) Thomas A Facility Reven (Front Auditation, post annex and names) Thomas A Facility Reven (Front Auditation, post annex and names) Thomas A Facility Revenue (Front Auditation, post annex and names) Thomas A Facility Revenue (Front Auditation, post annex and names) Thomas A Facility Revenue (Front Auditation, post annex and names) Thomas A Facility Revenue (Front Auditation, post annex and names) Thomas A Facility Revenue (Front Auditation, post annex and names) Thomas A Facility Revenue (Front Auditation, post annex annex and names) Thomas A Facility Revenue (Front Auditation, post annex a			1 - State Registrar				•	rtificate of			Reg. No.	2009	42	62
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Due to (or as a consequence of): Second of the second o	uted d ansit	min	cause. Enter Underlying Cause (Disease or injury	~	,		,							
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30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Troung Bao, MD 10110 Molecular Drive, #206 Rockville, MD 20850 State Registrar 31. Date filed (Month, Day, Year) PEC 17 2009 12-09-2009 12-09-2009 12-09-2009	Hospita 24 hours Funeral etely filler		(Check only 2 1		miner: On the ba	sis of exami								(s)
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Troung Bao, MD 10110 Molecular Drive, #206 Rockville, MD 20850 State Registrar 31. Date filed (Month, Day, Year) PEC 17 2009 12-09-2009 12-09-2009 12-09-2009	To the within To the Somple	Me	29b. Signature and title o	f certifier		,		29c. Licen	nse number		29d. Dat	te signed (Month,	, Day, Year)	
State Registrar 31. Date filed (Month, Day, Year) DEC 1 2009 Registrar's Signature	40		•			1	M					9-2009		
Registrar DEC 17 2009 Centra S. Jacks.			30. Name and address of Troung Bao,	MD 1	completed cause 0110 Mo1	of death (Ite ecular	em 23a) (Type Drive	, #206 Ro	ockville,	MD 208	350			
Registrar DEC 17 2009 Senters B. gares			31. Date filed (Month, Da	y, Year)	32. Re	gistrar's Sig	nature	40						
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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

Anne Elizabe	1	For State Certificate of Death	Reg. No. 2009 426
Physici Medical Exam	an/	I. Decedent's Name (First, Middle,Last)	Oate of Death Anoth Day Pear ecember 21, 2009 3. Time of Death 0138 hrs
nedical Exam		4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death	4c. County of Death
		Washington County Hospital Hagerstown	Washington
Funeral Director			Date of Birth (MM/DD/YYYY) 9. Birthplace (State or Foreign) 7/21/1952 Country) MA
	۱ ا	Usual Residence of Decedent 10a State 10b. County 10c. City, Town or Location	10d. Inside City Limits
w any		10a. State 10b. County 10c. City, Town or Location Sharpsburg	1 Yes 2 XNo
Maryland 28a-f show d at once.	호	10e. Street and Number 10f. Zip Code	10g. Citizen of What Country?
ith the Maryland 23a or 28a-f sho	Director	110 E. Chapline Street 21782	US
with the rs 23a		11. Marital Status 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specific	y Yes or No- an. etc.) 14. Race - American Indian, Black, White, etc.
death ritem nust b	Funeral	1 X Never Married 2 Married Armed Forces? 1 Yes 2 X No	I.Thrita
after (all, o	by F	3 Widowed 4 Divorced If Yes, Give Year or Dates:	Specify: White done 16b. Kind of Business/Industry
hours natur Exam	pa	15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work during most of working life. DO NOT use retired)	
36 in 72 han " dical I	plet	Elementary/Secondary (0-12) College (1-4 or 5+) 12 Project Manager	Healthcare
21215-0036 uld be filed within 72 Mental Hygiene. marked other than c event, the Medical	Completed	17. Father's Name (First, Middle, Last) 18. Mother's Name (Fir	rst, Middle, Maiden Surname)
215- 215- oe filed ntal Hyj ked ot	Be	Russell Harrison Gillis Jeanne	Marilyn Franzen
Baltimore, MD 21215-0036 permit. Pages I and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 213 is marked other than "natural", or items 23a or 28a-f she injury or other traumatic event, the Medical Examiner must be notified at once	P		Road, Hagerstown, MD 21/42
re, land land Healt Fitem		202. Method of Disposition 200. Flace (Cematory of other place)	ate 20c. Location - City or Town, State
MOI Pages ent of int: It		Smithsburg Crematory 12/23	/2009 Smithsburg, MD
Baltimore, permit. Pages 1 ar Department of Hee Important: If ite		21. Signature of Figure 1 Service Licensee 22. Name and Address of Facility Gera	ld N. Minnich Funeral Home
	_	23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or re	et, Hagerstown, MD 21740
Physiciar xamine		failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Due to (or as a consequence of):	Death
		h	
	ner	Sequentially list conditions, if any, leading to immediate Due to (or as a consequence of):	
	Examiner	cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death). Last events resulting in death). Last	
uted 1d ransit	Ĕ	d	
50, te be executed nysician and burial - transit	dical	X UNPENDED 23a,27, permE g899 1/28/10 TT	
760, cate be	Ĭ,	IF FEMALE: 23c. If yes, outcome of pregnancy	23d. Date of delivery Month Day Year
Box 6876(e death certificate the attending physel for use as the b	ian/M	23b. Was decedent pregnant in the past 12 months? 1 Live birth 2 Fetal death 3 Ectopic pregnance 4 Pregnant at time of death 5 Other (Specify)	l Month Bay real
SOX death e atter	Physic	1 Yes 2 No 9 Unknown g Unknown	
the check		Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.	23e. Did tobacco use contribute to the cause of death?
- 8 go a	–		1 Yes 2 No 3 Probably 4 Unknown
cords, law requires bear 2 should	lete		24a. Was an autopsy indings availab prior to completion of cause of
eco he law tte has	Completed		performed? death? 1 ✓ Yes 2 No 1 ✓ Yes 2 No
tal Records cian: The law requi certificate has been	Be C	25. Was case referred to medical 26.Place of Death (Check on	ly one)
Vits nysicia this ce	B	1 V Yes 2 No	Home 5 Residence 6 Other:
Of Viring Physical After this	Ë	(Month, Day Year)	8d. Describe how injury occurred
ion trendi death.	atio	1 X Natural 5 Pending 2 Accident Investigation	8f. Location (Street and Number or Rural Route Number, Cit
Division of Vital Records, tal or Attending Physician: The law requirer after death. al Director: After this certificate has been sind in but the fineral director nace? should be lad in but the fineral director nace?	Certification:	3 Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc.	or Town, State)
Hospi 24 hou Funer	sal Cer	4 Homicide 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and di (Check only	ue to the cause(s) and manner as stated. the time, date and place, and due to the cause(s)
To the within To the	Medical	and manner stated.	29d. Date signed (Month, Day, Year)
	2	29b. Signature and title of certifier 29c. License number O.C.M.E.	December 21, 2009
		10/4 00/11	
2511		30. Name and address of person who completed cause of death (Item 23a) Russell Alexander MD. Assistant Medical Examiner 111 Penn Street, Baltimore, MD	21201
3H-1	State		
	istra		
		•	

	Sta Registr		TED E. Howe 154 31. Date filed (Month, Day, Year) 050, 23, 2009	32. R gistrar's Signat		in wi	u Am	VOKT,	IMD C	1173	
- K	4-4		30. Name and address of person who complet			Print)	-			1705	-
	7 wit		29b. Signature and title of certifier	Chr		29c. Licenso		1	29d, Date signe		
	the Hos hin 24 h the Fun mpletely	Medical	(Check only 2 Medical Examiner: Cone)	on the basis of examinating manner stated.	tion and/or in	vestigation, in my o	pinion, death occu	irred at the time,	date and place,	and due to	the cause(s)
Divi	To the Hospital or Attending Phys within 24 hours after death. To the Funeral Director: After this completely filled in by the funeral directors.		29a. Certifier 12 Certifying Physician	e. Place of Injury - At ho building, etc. (Specify	v)		me date and place	City or To			
Division o	tending P leath. or: After t the funera	Certification:	1 Natural 5 Pending 2 Accident investigation	a. Date of Injury (Month, Day, Year)	28b. Time of Injury	M 1 🗆		28d. Describe	how injury occur	ed	
of Vital Records	Physician: this certific ral director, I	To Be	examiner? 1 ☐ Yes 2 ☑No Hospita	1 □ Inpatient 2 □			423-Nursing H		one) dence 6 □Oth	er (Specify)
tal	The ate		ADVANCED SEN 25. Was case referred to medical	nce De	EWEX	AITI	00 8	1 □Yes	2 No	death? 1 □ Yes	2 🗆 No
eco	e law requir has been s e 2 should	Completed	METAISOUL AUD	0515				24a. Was	psy	Were autop	sy findings available apletion of cause of
rds,	law requires that the as been signed by th 2 should be detache	þ	Part II. Other significant conditions contribut ACUTE RENAL F	-	uning in the ur	iderlying cause give	en in Part I.				ably 4 Unknown
P.O. Box 6	death certi e attending id for use a	Physician/Me	1 Yes 2 No 9 Unknown 9	yes, outcome of pregna ☐ Live birth 2☐ Fetal ☐ Pregnant at time of d ☐ Unknown	I death 3 [leath 5 [Ectopic pregnancy		220 Did t	Mo		Day Year
68760,	ficate be executed physician and s the burial-transit	edical Examiner	cause. Enter Underlying Cause (Disease or injury that initiated events c	Due to (or as a consequ							
r ⁱ	/Medical Examiner		resulting in death)	Due to (or as a consequ	-						- 0.11
	Physician		23a. Part 1. Enter the disease, or complication shock, or heart failure. List only one cau Immediate Cause (Final disease or condition	s that caused the death se on each line.	SHOC		g, such as cardiac	or respiratory a	rrest,	100	Approximate Interval Between Onset and Death Z DAYS
Ba	permi Depa Impo any ir		1 ingle St		42		ococheag	ue St. V	Williams		MD 21795
altimore,	permit. Pages 1 and Department of Heal Important: If item 2 any Injury or other once.		1 Remove 4 □ Donation 3 □ Remove 4 □ Donation 5 □ Other (Specify) 21. Sign ure of juneral state in nisee	ai irom State	e of He	eaven Cem	Dec.			Sprin	g,Maryland
ore, I	es 1 and 2: of Health a f item 27 is r other treu		Lanette G. Byrer - D	20b. P		Furnberry sition (Name of natory or other place		Date	20c. Location -		
Maryland	12 tre		19a. Informant's Name/Relationship (Type. Pr	*		g Address (Street	and Number or Ru				
lanc	should be fi and Mental H s merked ot umatic ever	To Be	17. Father's Name (First, Middle, Last) Frank M. Dorsey				18. Mother's Nam		odemer	ie)	
1212	filed within Hygiene. Ither than '		12	ollege (1-4or 5+)		Housewi		- /Ciuck Afindalio	Maides Comes	Home	
21215-0036	in 72 hc n "natu holicel	Completed	15. Decedent's Education (Specify only highest grade com		(Give	lent's Usual Occup kind of work done o OO NOT use retired	during most of worl	king	16b. Kind of Bi	usiness/Indi	ustry
980	be filed within 72 hours after death with the Maryland tial Hygiene. dother than "natural", or items 23a or 28a-f show event, the Modical Exa winst must be profilled at	by	1 Never Married 2 Married	☐Yes 2 XXX No Yes, Give earorDates:		□Yes 2√No	Specify:		Specify		
	ems 23	Funeral	550 Turnberry Driv	eas Decedent Ever in U.s med Forces?	S. 13. V	Vas Decedent of H f Yes, specify Cuba	414 ispanic Origin? (Spanic Origin? (Spanic Origin)	pecify Yes or No	14. Rac	USA e - America ck, White, et	
	with the	Director	10e. Street and Number	1		10f. Zip Code			10g. Citizen of V		ry?
	Maryla a-f sho	ctor	10a State 10b County West Virginia Jefferson			arles Tow	n				1 □ Yes 2XXNo
	Director		Usual Residence of Decedent	00	y, Town or Lo	nation		March	3,1924		d. Inside City Limits
	Funeral		5. Social Security Number 6. Sex	7. Age (In yrs. I		If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Bir (Month, Da March	th ay, Year)	9. Birthpla	ace (State or Foreign ry) Jersey
	Examir	ner	4a. Facility Name (If not institution, give street Williamsport Retir	·	age		Location of Death	1	4c. County	of Death ahing	ton
	Physici /Medic		Ann D. Getsinger					December 1	er 19 20	O ^{Year}	12:46 P M
			Registrar 1. Decedent's Name (First, Middle, Last)		Cer	tificate of L	Death	2. Date of De	Reg. No. 2	09	3. Nime of Death
			For State	ate of Marylan				Mental Hy	giene		

DHMH 17 Rev 1/2001

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			For State	State of Marylan				d Men		0000	12620
			Registrar		Cei	rtificate	of Death	125	Reg. No	10.2005	3. Time of Death
	Physicia	an	Decedent's Name (First, Middle, Last						Month D	ay Year	/ 1224.414
1	/Medic	al		Fluck		45 City T	own, or Location of De	aath	12	c. County of Dea	
J.	Examin	er	4a. Facility Name (If not institution, give	street and number)		46. City, 1	1			-	naton
_	- Francis		5. Social Security Number 6. Se	x 7. Age (In yrs.	last birthday)	If Under 1		Irs. 8. D	Date of Birth		thplace (State or Foreign
	Funeral Director			⊒м 2 ∑ г 87	Yrs.	Months	Days Hours M		Month, Day, Yea an。15—1		yland
	ט		Usual Residence of Decedent								
	arytan show	_	10a. State 10b. County	10c. City	y, Town or Lo	ocation					10d. Inside City Limits 1 X Yes 2 □ No
	Ba-f s	cto	Maryland Washingt	on 1	Hagers						
	ith th	Directo	10e. Street and Number			10f. Zip (Code		10g. (Citizen of What Co	ountry?
	ath w		333 Mill Street	10 W B 1 1 E 1 1 1	0 10		740) (Co coit)		USA 14. Race - Ame	orican Indian
	er de Item	Funeral	11. Marital Status 1 ☐ Never Married 2 ☐ Married	12. Was Decedent Ever in U. Armed Forces? 1 □Yes 2 No	.5. 13.	If Yes, speci	ent of Hispanic Origin? fy Cuban, Mexican, Pu	uerto Rica	n, etc.)	Black, Whi	
36	i', or	by F	3 ☑ Widowed 4 □ Divorced	If Yes, Give Year or Dates:		1 ☐ Yes 2	X No Specify:			Specify: [White
ĕ	within 72 hours after death with the Maryland ene. Than "natural", or itema 23a or 28a-f show ha Medical Examinar must be notified at	ted	15. Decedent's Edi	ucation	16a. Dece	dent's Usual	Occupation	adiaa	16b.	Kind of Business	/Industry
215	hin 7	Completed	(Specify only highest grad	College (1-4or 5+)	life.	DO NOT use	done during most of a retired)	Working			
2	filed wil Hygien ther th	Con	8	0	Ва	r pers				Tavern	
<u>n</u>	tal High office of other office of the other o	Be	17. Father's Name (First, Middle, Last)				18. Mother's	Name (Fir	st, Middle, Maid	en Sumame)	
<u>Y</u> a	should ind Men marke umatic	ဥ	Samuel Shaffer		10/ 14/33		Frie		unknown	Town State	Zin Cada)
Maryland 21215-0036	12 st h and 7 is n traun		19a. Informant's Name/Relationship (7)			,					
	permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hyliden. Department of Health and Mental Hyliden. Important: if Item 27 is marked other than "natural; or Itema 23a or 28a-f show eny injury or other traumatic event, the Musical Examinat must be notified at once.		Richard Nave - S 20a. Method of Disposition	20b. F	lace of Dispo	sition (Nam	etna Road,	Hag Date	erstown 20c.	Location - City or	740 Town, State
Baltimore,	Pages nent of 1 ant: if its arry or o		1 ☐ Burial 2 【 Cremation 3 ☐ 4 ☐ Donation 5 ☐ Other (Specify	Removal from State	cemetery, cre	,		/10//	00 17		
	artme ortan injur	- 1	21. Signature of Funeral Service Licens				ematory 12 Address of Facility			neral Ho	n, Maryland
Ba	permit. Departr Imports eny inju		> Took Event			415 E.	Wilson Bl				wland 21740
			23a. Part1. Enter the disease, or comp	lications that caused the deat							Approximate Interval Between
+	Physician		shock, or heart failure. List only o	a. Peripher	21 10	050	lar die	PM	CP		Onset and Death
Į	/Medical		disease or condition resulting in death)	a. Due to (or as a conseq			rich (XIS	CCC	30		
I	Examiner		Sequentially list conditions	. Dement							
	pg ti	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	Due to (or as a conseq	, .	0011	ar acc	in	pint		
	be executed ician and burial-transit	хап	that initiated events resulting in death) Last	C. Due to (or as a conseq		26 661	co cae	~((C / //		
760,	ite be executed ysician and ne burial-transit	cai E		. Huperto	ensi	00					
687	¥ × •	edic									
XO	anding use a	Z.	IF FEMALE: 23b. Was decedent pregnant	23c. If yes, outcome of pregna		⊒Ectopic pre	antes.			23d. Date of de	•
P.O. Box	that the death certifica ed by the attending phi detached for use as th	Physician/M	in the past 12 months? 1 ☐ Yes 2 ②No	1 Live birth 2 Feta 4 Pregnant at time of d 9 Unknown		Other (spe				Month	Day Year
o.	at the by th	hys	9 Unknown								
ŝ	Attending Physician: The law requires that the death certifica r death. colori. After this certificate has been signed by the attending phy the funeral director, page 2 should be detached for use as the funeral director.	P P	Part II. Other significent conditions co	ontributing to death but not res	sulting in the u	indertying ca	iuse given in Part I.				to the cause of death? Probably 4 Unknown
oro	w requires to been signer should be a	ted						-		1	
Sec	e taw has b	Completed						_	24a. Was an autopsy performed	prior to	autopsy findings available completion of cause of
E	Physician: The law this certificate has b al director, page 2 s								1□ Yes 2□		
Ë	iciar certif recto	Be	25. Was case referred to medical examiner?	Hospital:			Other		heck only one)	- To: (6)	
o	Phys r this aral di	. To	1 Yes 2 No 27. Manner of Death	28a. Date of Injury	ER/Outpatie		Bc. Injury at Work?		Describe how in	6 □Other (Sp njury occurred	eciny)
on	th. : Afte	ation	1 Natural 5 ☐ Pending 2 ☐ Accident investigation	(Month, Day Year)	Injury	м	Work? 1 ☐ Yes 2 ☐ No				
Division of Vital Records,	Atternation of the by the	HICE	3 ☐ Suicide 6 ☐ Could not be determined	28e. Place of Injury - At h		reet, factory	, office	28f.	Location (Street City or Town, St		Rural Route Number,
ō	taior rs afte al Dir	Certification:		building, etc. (opcor							
	To the Hospital or Attending I within 24 hours after death. To the Funeral Director: After completely filled in by the funer	Medical	(Check only 2 Medical Exam	ysician: To the best of my kno liner: On the basis of examina							
	To the I within 2 To the Complet	Med	one) 29b. Signature and title of certifier	and manner stated.		29c	License number		29d.	Date signed (Mor	nth, Day, Year)
	7 × 7 8		Nepto n	1 Smith	CPI		212808	8	1	2/18/1	09
		8	30. Name and address of person who	completed cause of death (Iter	m 23a) (Tvpa					1,00,0	09 MD 21740
اک	4-0		Kate M. Sm	ith CRN	0	3331	rill St.	tt	agers	toun.	MD 21740
- 3	Sta		31. Date filed (Month, Day, Year)	32. Registrar's Signa	ature	,					
	Regist	ar	OEC 22 2	III /	4	Ende					

DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 2009 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ 16, 10:10 pm Fernleigh R. Graninger December 2009 Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death Montgomery General Hospital Montgomery Olney Social Security Number 9. Birthplace (State or Foreign If Under 24 Hrs 8. Date of Birth **Funeral** 1 🗶 M 2 🗆 F April 01 Months Days Hours Min. .1915 Washington. Director 216-44-6974 94 Usual Residence of Decedent 1 and 2 should be filed within 72 hours after death with the Maryland of Health and Mental Hygiene.

Of Health and Mental Hygiene.

The stranger of the strang 10b. County 10c. City, Town or Location 10d. Inside City Limits Director 1 Tes 2 No Maryland Silver Spring Montgomery 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 15007 Peachstone Drive 20905 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian Armed Forces?

1 X Yes 2 No
If Yes, Give Black, White, etc. 1 Never Married 2 Married ģ Baltimore, Maryland 21215-0036 1 ☐ Yes 2 🛣 No Specify: 3 X Widowed 4 Divorced Specify: White Completed WWII Year or Dates. 15. Decedent's Education 16a. Decedent's Usual Occupation 16b, Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) College (1-4 or 5+) Elementary/Seconday (0-12) Division Chief U.S. Government Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Peter Graninger Carrie Rebecca Clark permit. Page 1 and 2 should be Department of Health and Men Important: If item 27 is marke any injury or other traumatic 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Robert L. Graninger - Son 1601 East Entrada Once, Tucson, AZ 85718 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place, 20c. Location - City or Town, State 1 🗆 Burial 2 💢 Cremation 3 🗆 Removal from State Ft. Lincoln Crematory 12/28/2009 Brentwood, MD 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Ligense 22. Name and Address of Facility Hines-Rinaldi Funeral Home. 11800 New Hampshire Ave., Silver Spring, MD 20904 23a. I rt 1. Suter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, so the seart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ Medical resulting in death) Examiner accident Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury attending physician and for use as the burial-transit that initiated events resulting in death) Last Physician/Medical Box 68760 IF FEMALE 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?
1 Yes 2 No 4 Pregnant at time of death 9 Unknown 5 Other (specify) Month Day Year ed by the a detached f 1 ☐ Yes 2 ☐ 9 ☐ Unknown been signed be should be deta Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 \square Yes 2 \square Yo 3 \square Probably 4 \square Unknown Records, 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an To the Hospital or Attending Physician: The I within 24 hours after death.

To the Funeral Director: After this cartificate h completed filled in by the funeral director, page performe 1 ☐ Yes 2 ☐ No 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 🗖 Ño ည 1 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of Certificate: 28c. Injury at Natural 5 Pending 2 Accident
3 Suicide
4 Homicide 1 Yes 2 No Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner stated 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one 29b. Signature and title of certi 2011 December 17, 2009

Division of Vital

State Registrar 18101

Prince Philip Dr., Olney,

Maryland 20832

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

M.D.

. Registrar's Signat

Rakhmanin

Vladimir M.

31. Date filed (Month, Day, Year)

			For State Registrar	ate of Maryland / De C	partment of Herificate of D			iene _{eg. No.} 2009	42632
	Physicia	an	1. Decedent's Name (First, Middle, Last)	Davis COLD			2. Date of Death Month	Day Year	3. Time of Death
we.	/Medic Examin	al	4a. Facility Name (If not institution, give street	Doris GOLD	4b. City, Town, or	Location of Death	December	15, 2009 4c. County of Deat	
		ei -	Holy Cross Hospital		Silver	Spring		Montgomer	
H	Funeral Director		5. Social Security Number 6. Sex 186-18-0551 1 □ M 2	7. Age (In yrs. last birthd	Months Days	Hours Min.	8. Date of Birth (Month, Day, Oct. 15		nplace (State or Foreign of untry) Poland
	ъ		Usual Residence of Decedent 10a, State 10b, County	10c. City, Town or	Location		00.0. 15	`*	10d. Inside City Limits
	Maryla a-f sho	tor	Maryland Montgom		ver Spring				1 ☐ Yes 2X No
	h with the 23a or 28a	al Director	10e. Street and Number 3 Autumn Court		10f. Zip Code	904		og. Citizen of What Co United Sta	
36	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hyglene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show amy injury or other traumatic event, I'm Modrel Everrinar must be notified at ance.	by Funeral	1 Never Married 2 Married 1	as Decedent Ever in U.S. med Forces?Yes2\frac{1}{2}\text{No} fes, Give ar or Dates;	3. Was Decedent of His If Yes, specify Cubar	spanic Origin? (Sp n, Mexican, Puerto Specify:	ecify Yes or No- Rican, etc.)	14. Race - Ame Black, White Specify: Wh	, etc.
2-00	72 hour	eted	15. Decedent's Education (Specify only highest grade com	16a. De	ecedent's Usual Occupa	ition uring most of worki	ing .	f 16b. Kind of Business/	ndustry
121	within ene. than "	Completed by			live kind of work done di te. DO NOT use retired) lomemaker	,g		Own Hor	ne
Maryland 21215-0036	d be filed ental Hygi ked other ic event,	To Be Co	17. Father's Name (First, Middle, Last) Zalmon	elsh		18. Mother's Name	e (First, Middle, M na (unkn	Maiden Surname) OWN)	
lary	2 shoul and M is marl aumati	F	19a. Informant's Name/Relationship (Type. Pr	′	ailing Address (Street a				
e, S	1 and Health Jem 27 Sther tr		Avra Gold, Son 20a. Method of Disposition		B Autumn Co sposition (Name of crematory or other place			ng, MD 20' 20c. Location - City or	904 Town, State
altimore,	Pages nent of int: If it		1 ABurial 2 □ Cremation 3 A Remov 4 □ Donation 5 □ Office (Specify)	al from State I	crematory or other place Memorial Pa		7/09	Lower Mo	reland, PA
Balti	Departing mporta Injurie.		21. Signature of Finien II Service Licensee		22. Name and Addres Torchinsky	s of Facility		ome	
	40 = 6 Q		23a. Part 1. Enter the disease, or complication	ns that caused the death. Do not	254 Carroll enter the mode of dying	S+ NIJ	Washin Br respiratory arre	gten, DC	20012 Approximate Interval Between
Jan.	Physician /Medical		Immediate Cause (Final disease or condition resulting in death)	se on each line. Conjestive Heari Due to (or as a consequence of):	t Failure				Onset and Death
	Examiner								
	uted I Insit	Examiner	Sequentially list conditions, if any, leading to instructions, if any, leading to instruction cause. Enter Underlying Cause (Disease or injury that initiated events c.	Due to (or se a consequence of):					
o,	icate be executed physician and the burial-transit		resulting in death) Last	Due to (or as a consequence of):					
68760,	ficate b physic s the b	edical	d						
P.O. Box	or Attending Physician: The law requires that the death certific bit and death certificate death. Differ death. Differ death. Differ contributes the strength of the time after this certificate has been signed by the attending in by the funeral director, page 2 should be detached for use as	Physician/Me	in the past 12 months?	yes, outcome of pregnancy □ Live birth 2 □ Fetal death □ Pregnant at time of death □ Unknown	3 Ectopic pregnancy 5 Other (specify)			23d. Date of del Month	ivery Day Year
rds, P.	w requires that the de sbeen signed by the should be detached	by	Part II. Other significant conditions contribut	ing to death but not resulting in th	e underlying cause give	n in Part I.		bacco use contribute to	o the cause of death?
Division of Vital Records,	The law rec cate has bee page 2 shou	Completed					24a. Was au autops perform 1 □ Yes 2	ned? prior to death?	utopsy findings available completion of cause of
Vita	sician; The certificate rector, pag	Be	25. Was case referred to medical examiner? 1 ☐ Yes 2 ☒ No Hospit	al: 1. Inpatient 2 ☐ ER/Outpa	Othe	26. Place of Deat			" <u>)</u>
n of	ding Phys h. After this funeral di	n:Tc		a. Date of Injury (Month, Day, Year) 28b. Tim	e of 28c. Injury			ence 6 ☐ Other (Spe ow injury occurred	спу)
ivisio	or Attendio ter death. irector: Ai irector by the fu	Certification: To	2 Accident investigation	e. Place of Injury - At home, farm, building, etc. (Specify)	M 1□1	∕es 2□No	28f. Location (St City or Town	treet and Number or Ri n, State)	ural Route Number,
Ω	. To the Hospital or Attendii within 24 hours after death. To the Funeral Director: A completely filled in by the fu	edical Ce	(Check only 2 Medical Examiner: (a: To the best of my knowledge, do On the basis of examination and/o					
h	To the Compl	Me	29b. Signature and title of cortifier	ayky.	29c. License D 63		2	29d. Date signed (Mont 12/15/09	h, Day, Year)
	*		30. Name and address of person who complet Maria J. Tayag, M.D.	, 1500 Főrest G	len Road,	Silver Sp	oring, M	D 20910	
	Sta Registr		31. Date filed (Month, Day, Year) DEC 18 2009	32. Degistrar's Signature	parke				

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 42633 For State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Physician/ Day Erma Louise Guido 2: 15 PM 2009 DECEMBER Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death BALTIMORE WASHINGTON Medical RNIE ARUNDEL center ANNE Social Security Number 6. Sex 7. Age (In yrs. last birthday) If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** Min. 1 M 2 X X Hours March 22, West Virginia Director 235 44 2664 82 Usual Residence of Decedent "natural", or items 23a or 28a-f shov edical Examiner must be notified at 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director MD Anne Arundel Odenton 1 Yes 2 X No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 21113 United States 1212 Odenton Road Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, 1 ☐ Yes 2 🔀 No If Yes, Give Completed by 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 🔀 No Specify: Specify: White 3

▼ Widowed 4 □ Divorced Year or Dates permit. Page 1 and 2 should be filed within 72 hour. Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natur any injury or other traumatic event, the Medical. 15. Decedent's Education 16a Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) College (1-4 or 5+) Elementary/Seconday (0-12) Registered Nurse Health Care Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Zeida B. Foster Hubert S. Knight RMA 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Sharon Lundstrom (Daughter) 752 Whitneys Landing Drive, Crownsville, MD 21032 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place, 20c. Location - City or Town, State 12/2672009 1 X Burial 2 Cremation 3 Removal from State Waldorf, MD Trinity Memorial Gardens 4 Donation 5 Other (Specify) 22. Name and Address of Facility Lee Funeral Home, Inc 6633 01d 21. Signat / Fune exandria Ferry Road, Clinton, MD Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ ACCIDENT EREBRO ASCULAR Medical resulting in death) Due to (or as a consequence of) Examiner Sequentially list conditions, Directo for as a nonsectiones of It any, leading to in mediat cause. Enter Underlying Cause (Disease or iinjury that initiated events Exam Due to (or as a consequence of): resulting in death) Last attending physician a for use as the burial-Physician/Medical Hospital or Attending Physician: The law requires that the death certificate be Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ____ in the past 12 months? Month Day Year Pregnant at time of death ned by the a 9 Unknown signed by t d be detach Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? by 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 🔀 Unknown Completed peen s 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has autopsy performed? within 24 hours after death.

To the Funeral Director; After this certificate 2 🗆 No 1 Yes 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Other: 4 \(\text{Nursing Home} \) 5 \(\text{Residence} \) 6 \(\text{Other} \) Other (Specify) 1 🗌 Yes 2 1 No ၉ 1 M Inpatient 2 ER/Outpatient 3 DOA 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at 28d. Describe how injury occurred Certificate: **X**Natural 5 Pending work? 1 ☐ Yes 2 ☐ No Accident M Investigation 3 ☐ Suicide 4 ☐ Homicide 6 Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) completed filled in by determined Medical 29a. Certifier 1 🔀 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. only one) 3[Certifying Nurse Practioner. To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certifier 29c, License number 29d. Date signed (Month, Day, Year,

State

Registrar DHMH 17 Rev 7/2009 ON

KHAWAJA

6465

301 HOSPITAL DR. GLENBURNIE,

W00 97

BWM

32. Registrar's Signature

Geneva

30. Name and address of person who completed cause of death (Item 23a) (Type, Print) FARODO

			State of Maryland / Department of Health and M 1 - State Register Certificate of Death		71111	9 42634
			Registrar 1. Decedent's Name (First, Middle, Last)	2. Date of Dea		3. Time of Death
	Physici /Medic		Helen Marie Grinder	Month ECEMB	ER"17 ac	509 8:55 PM
	Examin		4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death		4c. County of	Death PIES
	Funeral		5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs.	8. Date of Birth	Vear) 9.	. Birthplace (State or Foreign
	Director			8. Date of Birth (Month, Day tober 2	1,1963	Country) Maryland
	land bw		Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location			10d. Inside City Limits
	a-f sh	ctor	MD Prince Georges Upper Marlboro			1 ☐ Yes 2 ☐ No
	ift the	Director	10e. Street and Number 10f. Zip Code	1	0g. Citizen of Wha	at Country?
	eath w	Funeral	9229 Golden Rod Lane 20772 11 Marital Status 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Spe	ocify Ves or No-	USA 14 Bace -	American Indian,
036	2 should be filed within 72 hours after death with the Maryland and Mental Hyglene. Is marked other than "natural", or items 23a or 28a-f show aumatic event, the Medical Evandrent must be redified at	by	11. Marital Status 1 □ Never Married 2 □ Married Armed Forces? 1 □ Never Married 2 □ Married St.	Rican, etc.)		White, etc. White
21215-0036	72 hou	Completed	15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)	ng I	16b. Kind of Busin	iess/Industry
121	within ene. than "	du	Elementary/Secondary (0-12) College (1-4or 5+) Laboror		Construc	ction
<u>d</u>	ould be filed v Mental Hygie larked other i	Be Co	12 Eaborer 17. Father's Name (First, Middle, Last) 18. Mother's Name	(First, Middle,		2011
/lan	uld be Menta arked	To B	James Walton Thompson Mary Ann	Swann		
/au	d 2 should th and Men 7 Is marke traumatic	Ċ	19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rura			ate, Zip Code)
e,	Heal		Mary Perez/Daughter 2579 Robinson Place, W. 20a. Method of Disposition 20b. Place of Disposition (Name of Disposition)	aldorf,	MD 20602 20c. Location - Cit	
altimore, Maryland	permit. Pages Department of I Important: If ite any Injury or o		1 🛱 Burial 2 □ Cremation 3 □ Removal from State 4 □ Donation 5 □ Other (Specify) Christ Church Wayside 12/22	·	Wayside,N	Maryland
Ba	Depa Impo any I		21. Signature of uneral Service Licensee M01458 22 AREHART ECHOLS FUN 211 St. Mary's Ave			20646
	Physician		23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac of shock, or heart failure. List may one cause on each line. Immediate Cause (Final disease or condition as a factor of the cause o			Approximate Interval Between Onset and Death
r	/Medical Examiner		Due to (or and a consequence of):			
	P +	ner	Sequentially list conditions, if any, leading to immediate cause. E. iter Underlying Cause (Disease or injury that initiated events			
	ecutec and transit	Examiner	Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of):		_	
8760,	ficate be executed physician and s the burial-transit	alE	Due to (or as a consequence of):			
	tificate g phys as the	edical	d			
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rds, P.	The law requires that the drate has been signed by the sage 2 should be detached	þ	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.	23e. Did to		ute to the cause of death?
I Records,	The lar	Completed		24a. Was a autop: perfor 1 □ Yes	sy prio med2 dea	ere autopsy findings available or to completion of cause of ath?]Yes 2 □ No
Zita Zita	sician: certific irector,	Be	25. Was case referred to medical examiner? Hospital: Hospital: OFFICIENT AFFICIAL Other:			
ō	ding Phys h. After this funeral di	ب: 1 و	27. Manner of Death 28a. Date of Injury 28b. Time of 28c. Injury at 2		ence 6 Other ow injury occurred	·
Ö	ath. ath. ir: Afte	atio	U⊠Natural 5 □ Pending (Month, Day, Year) Injury Work? 2 □ Accident investigation M 1 □ Yes 2 □ No			
Division of Vital	Hospital or Attending Physiclan: 24 hours after death. Funeral Director: After this certified etely filled in by the funeral director, p	Certification:	3 ☐ Suicide 6 ☐ Could not be determined 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)	28f. Location (S City or Tow	treet and Number n, State)	or Rural Route Number,
	To the Hospital or At within 24 hours after of To the Funeral Direct completely filled in by	edical (29a. Certifier (Check only one) 1. Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and manner: On the basis of examination and/or investigation, in my opinion, death occurred and manner stated.			
	To the within 2 To the comple	Σ	29b. Signature and title of certifier Diesslan Hebtergris, MD D0069154		29d. Date signed (1	Month, Day, Year)
B.	25		30. Name and address of person who completed cause of death (Item 23a) (Type, Print) DRESSLGN HABTGIORGIS MD 5 GARRETT A	AUE L	APLATA	1MD2064
	Sta Registr		31. Date filed (Month, Day, Year) DEC 2 2 2009 32. Registrar's Signature B. Sparks			

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ DECEMBER THOMAS WILLIAM HOWARD 6:05 PM Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death FREDERICK MEMORIAL HOSPITAL FREDERICK FREDERICK Social Security Number If Under 1 Year If Under 24 Hrs. 6. Sex 7. Age (In vrs. last birthday) 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** 227-22-9043 Months Days Hours (Month, Day, Year) May 20, 1926 1 🔀 M 2 🗆 F Virginia Director Yrs 83 Usual Residence of Decedent ral", or items 23a or 28a-f shov Examiner must be notified at 10a. State 10b. County with the Maryland 10c. City, Town or Location 10d. Inside City Limits Director Maryland Frederick Frederick 1 X Yes 2 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 990 Waterford Drive 21702 United States 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Armed Forces? Black, White, etc. þ 1 Never Married 2 Married 72 hours after Baltimore, Maryland 21215-0036 If Yes, Give Year or Dates 1 ☐ Yes 2 X No Specify: "natural", Specify: White Completed 3 Widowed 4 Divorced event, the Medical 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Page 1 and 2 should be filed within 72 nent of Health and Mental Hygiene. ant: If item 27 is marked other than ' Elementary/Seconday (0-12) College (1-4 or 5+) Radio Broadcaster Broadcasting Media Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ပ William T. Howard, Sr. Miriam Sowers 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Anne H. Blough / Daughter 7 Stine Court, Middletown, Maryland 21769 permit. Page 1 and 2 Department of Health Important: If item 2: any injury or other tonce. 20a. Method of Disposition 20b. Place of Disposition (Name of Date 20c. Location - City or Town, State Mount Olivet Cemetery January 2, 1 X Burial 2 Cremation 3 Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Frederick, Maryland 2010 22. Name and Address of Facility Keeney & Basford P.A. Funeral Home 106 East Church Street, Frederick, Maryland 21701 Signature of Funeral Service Licer M01433 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line Interval Between Immediate Cause (Final Onset and Death Ph sician/ 119 disease or condition resulting in death) Medical Due to (or as a comequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Due to (ur as a consequence u) Exami Cause (Disease or iinjury the burial-transi the attending physician and that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical Hospital or Attending Physician: The law requires that the death certificate be 24 hours after death. Division of Vital Records, P.O. Box 68760 use as IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery Ectopic pregnancy for in the past 12 months?
1 Yes 2 No 5 Other (specify) Month Year Pregnant at time of death 9 Unknown within 24 hours after death.

To the Funeral Director: After this certificate has been signed by to completed filled in by the funeral director, page 2 should be detact. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by INJIM 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed Yes 2 No 1 🗌 Yes 2 🗌 No 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital 2.X No Other: မ 1 🗌 Yes 1 Inpatient 2 I ER/Outpatient 3 I DOA 4 Nursing Home 5 Residence 6 Other (Specify) Certificate: 27. Manner of Death 28a. Date of injury 28b. Time of 28c. Injury at 28d. Describe how injury occurred (Month, Day, Year) 1 Natural 5 Pending 2 Accident
3 Suicide 1 Tyes 2 🗌 No Investigation 6 Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide determined Medical 29a. Certifier 1 💢 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check only one) 29b. Signature and title of certifie 29c. License number 29d. Date signed (Month, Day, Year) 12 riten 0 arre 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

A. Austin Pearre, Jr., M.D. 300 West Ninth Street, Frederick, Maryland 21701

State Registrar 31. Date filed Monto 7, 2010

32. Registrar's signatu

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 12-26-2009 **Physician** Harold Elsworth Hosier 12:22 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Kline Hospice House Mt. Airy Frederick If Under 1 Year | If Under 24 Hrs. 9. Birthplace (State or Foreign Country) 8. Date of Birth (Month, Day, 6-1-191 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** Year) Days Hours 178-07-8838 94 Director Usual Residence of Decedent filed within 72 hours after death with the Maryland 10c. City, Town or Location 10d. Inside City Limits r than "natural", or items 23a or 28a-f show the Medical Expreiser must be notified at 1 ☐ Yes 2 TNo Director Frederick Frederick 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 21701 USA 6351 Spring Ridge Parkway, Apt 347 Completed by Funeral 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black White, etc. 1 TXYes 2 No
If Yes, Give
Year or Dates: 44-46 1 Never Married 2 Married Maryland 21215-0036 1 ☐ Yes 2 📉 No Specify: 3 Widowed 4 Divorced White Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) Agent Insurance . Pages 1 and 2 should be filed wi tment of Health and Mental Hygien tant: If item 27 is marked other th jury or other traumatic event, the 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Elmer Hosier Ethel Kiefer ဂ္ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 6351 Spring Ridge Parkway, 347 Frederick, MD 21701 Mary Hosier Wife Baltimore, 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 1 ☐ Burial 2 X Cremation 3 ☐ Removal from State permit. Page Department o Important: If any injury or Smithsburg Crematory 12-27-2009 4 ☐ Donation 5 ☐ Other (Specify) Smithsburg, Maryland 22. Name and Address of Facility Keeney & Basford P.A. F.H. 21. Signature of Funeral Service bicense M01176 106 East Church Street Frederick, MD 21701 23a. Part 1. Ever the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death METARTATIC Immediate Cause (Final disease or condition resulting in death) PROSTATE Physician /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, reading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to for sels consequence off burial-trar Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760 attending physician Physician/Medical as the I for use 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant in the past 12 months? 23d. Date of delivery 3 Ectopic pregnancy Month Day Year 4 ☐ Pregnant at time of death 9 ☐ Unknown 5 Other (specify) 1 □Yes 2 □No 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. ģ þe 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has autonsy Hospital or Attending Physician: The perform certificate 1 ☐ Yes 2 ☐ No 1 ☐ Yes Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 Yes 2 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To completely filled in by the funeral 28a. Date of Injury (Month, Day, Year) 28b. Time of Injury 27. Manner of Death 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural 2 Accident 5 Pending investigation 1 ☐ Yes 2 ☐ No after death Director: 6 ☐ Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 24 hours a 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) Medical within 2 To the I 29c. License number 29d. Date signed (Month, Day, Year) P31761 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

10

State Registrar 31. Date filed (Month, Day, Year)

32. Registra's Si

W. SEVENTH ST.

FREDENICK

State of Maryland / Department of Health and Mental Hygiene Certificate of Death 3. Time of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Day 2009 ear Month **Physician** 1:28 A M Dec. 20, Ralph B. Harris /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner Baltimore 20419 Downs Road Parkton If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Months Days Hours Min. May Year May 31, 1 Birthplece (State or Foreign
Country) 5. Social Security Number 7. Age (In vrs. last birthday) **Funeral** Months 1**X**M 2□F 1946 220-40-7760 63 Virginia Director Usual Residence of Decedent 10d. Inside City Limits 10c. City. Town or Location 10a, State 10b. County or 28a-f show and be notified at 1 Yes 2 No MD Baltimore Parkton Funeral Director 10g. Citizen of What Country? 10f. Zip Code 10e, Street and Number USA 20419 Downs Rd. 21120 itema 23e death 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 █ No If Yes, Give Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puento Rican, etc.) 14. Race - American Indian, 11. Marital Status the Medical Examiners Black. White, etc. 1 ☐ Never Married 2 X Married 5 White Baltimore, Maryland 21215-0036 1 ☐ Yes 2X No Specify: Specify: δ 3 Widowed 4 Divorced Year or Dates: *naturel Completed 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation 15. Decedent's Education (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) Elementary/Secondary (0-12) than College (1-4or 5+) Construction Carpenter s 1 and 2 should be filed w f Health and Mental Hygier frem 27 is marked other th 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Laura P. Thomas John H. Harris traumatic 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Pages 1 and 2:
Department of Health ar
Important; if item 27 is
any injury or other trau 20419 Downs Rd., Parkton, MD 21120 Joyce L. Harris, Wife 20b. Place of Disposition (Name of cemetery, crematory or other place)
Cremation Dec. Data 22, 20c. Location - City or Town, Stete 20a. Method of Disposition 1 Burial 2 Cremation 3 Removal from State York, PA 2009 * 4 ☐ Donation 5 ☐ Other (Specify) Direct Service 21 Signeture of Fune al Bovica License 22. Name and Address of Facility J.J. Hartenstein Mortuary, Inc. 24 Second St., New Freedom, PA 17349 anes 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** /Medical Due to (or as a-c **Examiner** Sequentially list conditions, it any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner or Attending Physician: The law requires that the death certificate be executed use as the burial-transit Box 68760,4 Due to (or as a consequence of) the attending physicien Physician/Medicai IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Month Day Year in the past 12 months? 1 ☐ Yes 2 ☐ No 4 Pregnant at time of death 5 Other (specify) P.O. detached 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Division of Vital Records, ģ page 2 should be 3 Probably 4 Unknown 1 ☐ Yes 2 ☐ No Be Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 □ Yes 2 □ No 24a. Was an certificate has autopsy performed 25. Was case referred to medical examiner? funeral director, 26. Place of Death (Check only one) Hospital: 1 ☐ Inpatient Other: 4 Nursing Home 5 Hesidence 6 Other (Specify) 3 DOA 1 Yes 2 ER/Outpatient Certification: To this 28c. Injury at Work? 28a. Date of Injury (Month, Day Year) 28b. Time of 28d. Describe how injury occurred Manger of Death After 1 Natural 2 ☐ Accident 5 Pending 1 Yes 2 No investigation within 24 hours after death. To the Funeral Director: A 6 Could not be determined 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 ☐ Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) filled in by 4 Homicide To the Hospital Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Exeminer: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical completely (Check only one) and manner stated. 29b. Signature and title of certifier 0 30. Name and address of person who comp ered cause of death (Item 23a) (Type, Print) 32. Registrar's Signature 31. Date filed (Month, Day, Year) State **20**10 Registrar

State of Maryland / Department of Health and Mental Hygiene Certificate of Death Date of Death
 Month 1. Decedent's Name (First, Middle, Last) **Physician** 25, Iyaunna Nashae Herbert 2009 5:30 December /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death Examiner 4b. City. Town, or Location of Death St. Mary's St. Mary's Hospital Leonardtown If Under 1 Year | If Under 24 Hrs. Birthplace (State or Foreign Country) 5. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) **Funeral** Days Hours Months 1 □ M 2 🛛 F 5 215-69-4262 March 17,2004 Director Maryland Usual Residence of Decedent filed within 72 hours after death with the Maryland Hygiene. 10d. Inside City Limits 10b. County 10c. City, Town or Location d other than "natural", or items 23a or 28a-f show event, the Medical Evaniner must be notified at 1 ☐ Yes 2 ☑ No Director Marvland St. Mary's Callaway 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 20890 Hunting Quarter Drive 20620 USA Completed by Funeral 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 ☐ Yes 2 📆 No If Yes, Give Year or Dates: 1 X Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 1 □Yes 2 🛛 No Black Specify: 3 Widowed 4 Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Never Worked is marked other 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be 1 and 2 should be Health and Mental Twanda Michelle Chase Thomas Larvell Herbert 2 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Pages 1 and 2 s
Department of Health ar
Important: If item 27 is
any injury or other trau
once. Twanda M. Herbert / Mother 20890 Hunting Quarter Drive Callaway, MD 20620 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State December 31. 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State Queen of Peace Cemetery 4 □ Donation 5 □ Other (Specify) 2009 Helen, Maryland 22. Name and Address of Facility
Mattingley-Gardiner Funeral Home, P.A. P.O. Box 270 Leonardtown, MD 20650 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** Cardiac Minutes /Medical Due to (or as a consequence of): **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner that the death certificate be executed Due to (or as a consequence of): burial-1 Physician/Medical attending IF FEMALE: 23c. If yes, outcome of pregnancy

1 Live birth 2 Fetal death
4 Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 🗆 Ectopic pregnancy for in the past 12 months? Month Day Year 5 Other (specify) P.0. detached 9 I Inknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Records, þ 1 Yes 2 No 3 Probably 4 Unknown page 2 should Be Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an autopsy performe Viita director, 25. Was case referred to medical examiner? 26. Place of Death (Check only one, Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 🗌 Yes Medical Certification: To of 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of Injury 28c. Injury at Work? 28d. Describe how injury occurred Hospital or Attending Natural
2 Accident 5 Pending 1 ☐ Yes 2 ☐ No investigation within 24 hours after death. To the Funeral Director: A filled in by the 3 Suicide 6 Could not be determined 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier completely (Check only one) and manner stated. 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month. Day, Year) 30. Name and address of Person who completed cause of death (Item 23a) (Type, Print) ORME MD 29650 ECIVARDTOWN P.O. BOX AMIT 31. Date filed (Month, 32. Regietrar's Signature Registrar

DHMH 17 Rev 1/2001

Idauna

erbert

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 2. Date of Death Month Physician/ dWISUN 1021 12 Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Arnold Anne Arundel 468 Broadwater Road . Social Security Number 9. Birthplace (State or Foreign If Under 1 Year If Under 24 Hrs. 7. Age (In vrs. last birthday) 8. Date of Birth Funeral 1 M 2 Z F Hours (Month, Day, Y 84 **Director** 391-20-5443 1925 Wisconsin Usual Residence of Decedent 27 is marked other than "natural", or items 23a or 28a-f show traumatic event, the Medical Examiner must be notified at 10a. State 10b County filed within 72 hours after death with the Maryland 10c. City, Town or Location 10d. Inside City Limits Director MD Anne Arundel Arnold 1 Yes 2 X No 10e Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 468 Broadwater Road 21012 USA 11. Marital Status 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 ☐ Yes 2 🔀 No If Yes, Give þ 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify: White Specify: 3 x Widowed 4 ☐ Divorced Completed Year or Dates 15. Decedent's Education 16a Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) permit. Page 1 and 2 should be filed within Department of Health and Mental Hygiene. Important: If item 27 is marked other than any injury or other traumatic event, the Nay injury or other traumatic event. Office 12 Bookkeeper Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Robert Anton Handel Cecelia Dasey 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Linda Howison Barr / Daughter 1067 Saint Margarets Drive Annapolis, MD 21401 Date 6, 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State 1 🔀 Burial 2 🗆 Cremation 3 🗀 Removal from State cemetery, crematory or other place) Dec. Crownsville, MD MD Veterans Cemetery 4 Donation 5 Other (Specify) 2009 22. Name and Address of Facility Barranco & Sons, 495 Gov. Ritchie 21. Signature of Funeral Service Licenses P.A. Hwy, Severna Park Funeral H Severna Park, MD 21146 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Immediate Cause (Final Onset and Death Physician chrom disease or condition Medical resulting in death) Due to (or as a consequence of): Examiner EARLY Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examine Due to (or as a consequence of) Hospital or Attending Physician: The law requires that the death certificate be executed Cause (Disease or linjury that initiated events physician and s the burial-trans Due to (or as a consequence of): resulting in death) Last Physician/Medical Box 68760 as IF FEMALE: for use 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 1 ☐ Live Birth
4 ☐ Pregnant a
9 ☐ Unknown in the past 12 months? Month Day Year Pregnant at time of death as been signed by the 2 should be detached 9 Unknown Records, P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 Yes 2 No 3 Probably 4 Unknown . Were autopsy findings available prior to completion of cause of 24a. Was an has autopsy page death? certificate 1 Yes 2 No Yes Division of Vital 25. Was case referred to medical 26. Place of Death (Check only one) Be examiner? Hospital 2 No 1 Tes မ 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) this 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at Certificate: 28d. Describe how injury occurred After injury 1- Natural 5 Pending work? 1 ☐ Yes 2 ☐ No after death.

I Director: Aff 2 Accident Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, completed filled in by 4 Homicide determined City or Town, State) 24 hours a Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check within 2 only one) 29b. Signature and title of who completed cause of death (Item 23a) (Type, Print ENTA M 44(31. Date filed (Month, Day, Year) Registrar's Signatur State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month Day December 11, **Physician** 2009 12:30 PM James Duane Hopkins /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner Montgomery Wilson Health Center Gaithersburg If Under 1 Year | If Under 24 Hrs. Birthplace (State or Foreign Country) 5. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) **Funeral** 1XM 2□ F Months Days Hours Jan 15, Director 579-36-3136 1930 Colorado Usual Residence of Decedent the Maryland 10c. City, Town or Location 10d. Inside City Limits 10a. State 10b. County show 7 is marked other than "natural", or items 23a or 28a-f shoi traumatic event, the Medical Examinar must be notified at 1 ☐ Yes 2 X No Director MD Bethesda Montgomery 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? USA 20816 Funeral 4910 Berkley Street Pages 1 and 2 should be filed within 72 hours after death 12. Was Decedent Ever in U.S. Armed Forces? 1 XYes 2 ☐ No Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. 11. Marital Status 1 XYes 2 No
If Yes, Give
Year or Dates: 1951-53 1 Never Married 2 Married 3altimore, Maryland 21215-0036 1 ☐Yes 2 XNo Specify. Specify: White Ş Q 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) n and Mental Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) 12 <u>Unde</u>rwriter Insurance 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Verda Estella House George Wellington Hopkins ပ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Item 27 is other tra 4910 Berkley Street Bethesda, MD 20816 Maryalys H. Hopkins/wife 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State Department of H Important: If iter any injury or oth once. 1 ☐ Burial 2 XCremation 3 ☐ Removal from State Final Journey Crematory 12/16/09 Woodbine, MD 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licens Going Home Cremation Service P.O. Box 784 MO1251Beverly L. Heckrotte, P.A. Clarksville, MD 21029 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician A crite cornary insiles disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to (or as a consequence of) The law requires that the death certificate be executed attending physician and for use as the burial-transit Due to (or as a consequence of) P.O. Box 68760, Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death
9 ☐ Unknown 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months? 3 Ectopic pregnancy Month Day Year 5 ☐ Other (specify) signed by the a 1 ☐ Yes 2 ☐ No 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? of Vital Records, þ Righthem 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an performed; Dementia certificate 2 1 No 1 ☐ Yes 2 ☐ No 1 ☐ Yes To the Hospital or Attending Physician: within 24 hours after death.

To the Funeral Director: After this certifica completely filled in by the funeral director, p 25. Was case referre o medical examiner? Be 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of 28d. Describe how injury occurred Division 1 Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 ☐ Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a, Certifier Medical (Check only one) 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifier 201 RUSSELL AVENUE GAITHERSBURY, MIS. 20847. 14. R. Kertsi

Registrar DHMH 17 Rev 1/2001

State

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

32. Registrar's Signature

Serena

J. Robert BIRSCHBACH,

31. Date filed (Month, Day, Year)

Physician Medical Examinar Jason Michael Harpster J	Jason Michael F			tate of Maryla	and / Depar	tment of	Health an		Hygiene	2.0	00 1.261	. 1
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30. Name and address of person who completed cause of death (Item 23a)			30. Name and address of person	n who completed cau	se of death (Item 2	23a)						
Margarita Korell MD. Assistant Medical Examiner 111 Penn Street, Baltimore, MD 21201	φ			· ·			enn Street, E	Baltimore, M	/ID 21201			
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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Day Year **Physician** Рм 2009 15 Harold H. Hutchinson /Medical 4b. City, Town, or Location of Death 4c. County of Death 4a. Facility Name (If not institution, give street and number) Examiner Charles Genesis LaPlata Nursing & Rehab. Ctr LaPlata Birthplace (State or Foreign Country) 8. Date of Birth (Month, Day, Year) Social Security Number 7. Age (In yrs. last birthday) **Funeral** Hours Months Days Min. 1X M 2□ F Cheverly, MD 4/16/1941 68 Director 218-38-6824 Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 10a. State 7 is marked other than "natural", or items 23a or 28a-f show traumatic event, the Medical Experiment, and by natified at 1X Yes 2 ☐ No Director Indian Head Charles 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number death with USA 20640 6290 Chicamuxen Road Funeral Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 12. Was Decedent Ever in U.S Armed Forces? 11. Marital Status Black, White, etc. 72 hours after 1 □Yes 2 X No If Yes, Give Year or Dates: 1 ☐ Never Married 2 ☐ Married Specify: White 1 ☐ Yes 2 No Baltimore, Maryland 21215-0036 Specify. à 3 Nidowed 4 Divorced Completed 16b. Kind of Business/Industry 16a, Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Pages 1 and 2 should be filed within Department of Heath and Mental Hygiene Important: If tem 27 is marked other than any injury or other traumatic event, the Maonee. Elementary/Secondary (0-12) College (1-4or 5+) Home Renovations Floorman 10 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Eleanor G. Hutchison မှ James Arnold Hutchinson 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) Indian Head, MD 20640 6290 Chicamuxen Road <u>Frederick Hutchinson - Son</u> 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20a. Method of Disposition 1 N Burial 2 ☐ Cremation 3 ☐ Removal from State oln Cemetery 12/21/09 Brentwood, MD
22. Name and Address of Facility Ft. Lincoln Funeral Home, Inc. 4 ☐ Donation 5 ☐ Other (Specify) Ft.Lincoln Cemetery 21. Signature of Funeral Service Licensee 23a. Part 1. Ever the disease, of complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Medical 3401 Bladensburg Road Brentwood, MD 20722 Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Due to (or as a consequence of) Physician/Medical Examiner Hospital or Attending Physician: The law requires that the death certificate be executed and use as the burial-tran resulting in death) Last Due to (or as a consequence of): P.O. Box 68760, attending physician for use as the buria IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Month Day Ye*a*r in the past 12 months? 5 Other (specify) been signed by the should be detached 1 ☐ Yes 2 ☐ No 9 I Unknown 9 🗌 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Division of Vital Records, Completed by 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an perform 1 ☐Yes 2 ☐No 2 No certificate 1 ☐ Yes 26. Place of Death (Check only one) funeral director, 25. Was case referred to medical Be Other: 4 ☑ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 1 Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA Certification: To this 28a. Date of Injury (Month, Day, Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 27 Manner of Death After 1 Natural 5 Pending 1 ☐ Yes 2 ☐ No death. ours after death.
neral Director: A
filled in by the fu investigation 2 Accident 6 ☐ Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) determined 4 Homicide within 24 hours a

To the Funeral C

completely filled Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier

CR

State Registrar WILLIAM

DEC 22

DHMH 17 Rev 1/2001

7350 Van DUSEN RD SUITE 350

30. Name and address erson who completed cause of death (Item 23a) (Type, Print)

I.CRI

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

AMEND ITEM#5perINF, G900, 2/2672010, WS
State of Maryland / Department of Health and Mental Hygiene 42643 For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ HANIF 2009 1904 MOHAMAD Medical 4a. Facility Name (if not institution, give street and numb Examiner 4b. City, Town, or Location of Death 4c. County of Death MONTGOMERY SHADY GROVE ADVENTIST HOSPITAL OCKVILL 5. Social Security Number 1 6. Sex 1 ☑ M 2 ☐ F If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Yea. 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign **Funeral** Months Hours GOYANA Director Usual Residence of Decedent or 28a-f show "natural", or items 23a or 28a-f shoredical Examiner must be notified at 10a. State 10c. City, Town or Location 10d. Inside City Limits filed within 72 hours after death with the Maryland Director MD CLARKSBURG MONTGOMERY 1 Yes 2 □ No 10e. Street and Number 10g. Citizen of What Country? Funeral 208 14901 USA-BENNE 12. Was Decedent Ever in U.S. Armed Forces?

1 Yes 2 No If Yes, Give Was Decedent of Hispanic Origin? (Specity Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Completed by 1 Never Married 2 Married 3altimore, Maryland 21215-0036 1 Yes 2 No Specify: Specify: EAST INDIAN 3 Widowed 4 Divorced Year or Dates the Medical 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry permit. Page 1 and 2 should be filed within 72 h. Department of Health and Mental Hygiene. Important: If flem 27 is marked other than "na any injury or other traumatic event **L-**. (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) MOSQUE College (1-4 or 5+) Elementary/Seconday (0-12) ARE TAKEK Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) မ SAHADA KHATIJAN SAHADAT MOHAMED 19a. Informant's Name/Relationship (Type, Print) SON-IN-LAN 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 20871 14901 BADRUDEEN BENNETT DR. CLARKSBURG BACCHUS ITTLF. 20b. Place of Disposition (Name of cemetery, crematory or other place) DEN AL-FIRDAUS MEMORIAL 20a. Method of Disposition 20c. Location - City or Town, State 1 Burial 2 Cremation 3 Removal from State AUS MEMORIAL 12/21/09 FREDERICK MD-22. Name and Address of Facility ADEN MUSLIM FUNERAL 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee EASY ST. WOODBRIDGE VA 2219 SER. 1242 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or reshock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Acute Prysician Myocardial disease or condition OUYS Medical resulting in death) Examiner RAYS Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury that initiated events resulting in death) Last Examine Due to (or as a consequence of sician and burial-transit Due to (or as a consequence of): attending physician Physician/Medical requires that the death certificate be Box 68760 the as IF FEMALE: nse yes, outcome of pregnancy 23b. Was decedent pregnant 23d. Date of delivery Live Birth 2 Fetal death Pregnant at time of death 3 Ectopic pregnancy 5 Other (specify) jo in the past 12 months? Month Day Year Yes 2 No page 2 should be detached the 9 Unknown Division of Vital Records, P.O. signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? δ 1 Yes 2 No 3 Probably 4 Unknown Completed peen 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an Hospital or Attending Physician; The law has autopsy performe 24 hours after death. Funeral Director: After this certificate 1 Yes 2 No 25. Was case referred to medica funeral director, 26. Place of Death (Check only one) Be examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Tes 2 X No ပ 1 XInpatient 2 ☐ ER/Outpatient 3 ☐ DOA 27, Manner of Death 28b. Time of 28a. Date of injury 28c. Injury at 28d. Describe how injury occurred Certificate: 1 Natural
2 Accident
3 Suicide
4 Homicide (Month, Day, Year) 5 - Pending injury work? 1 ☐ Yes 2 ☐ No. Investigation completed filled in by the 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier 2 Delignment Delignment On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Deritfying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check within 2 only one 29b. Signature and title of certifie 29c. License number 29d. Date signed (Month, Day, Year) 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) TINE MD 25 SHADY GROVE RD. #201 State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene $2 \cap Q$ Certificate of Death Rea. No 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Dav **Physician** RACHEL HURT DEC /Medical 2009 2:45A 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner HYATTSVILLE THOMAS MOORE NURSING HOME PRINCE GEORGE'S 5. Social Security Number 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) Date of Birth (Month, Day, Year) **Funeral** Min. 1 □ M 2 □ F Months Days Hours Director 579-68-5161 6/16/1933 VIRGINIA Usual Residence of Decedent filed within 72 hours after death with the Maryland 10b. County 10c. City, Town or Location 10d, Inside City Limits ral", or items 23a or 28a-f show Evandrer must be notified at MD PRINCE GEORGE'S Director 1XYes 2 □ No CAPITOL HEIGHTS 10e. Street and Number 10f, Zip Code 10g. Citizen of What Country 1919 NOVA AVE Completed by Funeral 20743 UNITED STATES 12. Was Decedent Ever in U.S. Armed Forces? 11. Marital Status Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 1 Yes 2 No If Yes, Give Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 □Yes 2√□No Specify: Specify: BLACK "natural", 3 ☑ Widowed 4 ☐ Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) 1 and 2 should be filed within Health and Mental Hygiene. College (1-4or 5+) PRIVATE <u> 12th</u> DOMESTIC 17. Father's Name (First, Middle, Last) it. Pages 1 and 2 c... artment of Health and Mentai noortant: If item 27 is marked of the artnumatic eve 18. Mother's Name (First, Middle, Maiden Surname) Be WALTER WATKINS ပ EVA RICHIE 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) BRENDA BANKS/DAUGHTER 1919 NOVA AVE CAPITOL HEIGHTS, MD. 20743 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place Date 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) permit. Page Department o Important: If any injury or GLENWOOD CEMETERY 12/30/09 WASHINGTON, DC 22. Name and Address of Facility CAPITOL MORTUARY 21. Signature f Funeral Service License 1425 MARYLAND AVE., NE WASHINGTON, 2802 23a. Part. Enter the disease, or co mplications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, y one caus, on each line. Immediate Cause (Final disease or condition resulting in death) **Physician** the vo sclerch /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to for as a consequence of Hospital or Attending Physician: The law requires that the death certificate be executed and Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, ned by the attending physician detached for use as the burial Physician/Medical 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 🗆 Ectopic pregnancy in the past 12 months? 5 Other (specify) 1 □Yes 2X□No 9 Hinknown 9 Unknown signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has performed' 2 □No 1 □ Yes 2 1 No 1 ☐ Yes 25. Was case referred to medica examiner? Be 26. Place of Death (Check only one) Other: 4 Aursing Home 5 Residence 6 Other (Specify) 1 | Yes 2 | No Certification: To 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 27. Manner eath 28a. Date of Injury (Month, Day, Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural 5 Pending investigation Injury 2 Accident 1 □Yes 2 □ No 24 hours after deatl Funeral Director: filled in by the 6 ☐ Could not be 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical 29a, Certifier (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. within 2 To the I 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 29c. License number

30. Name and address of person who completed cause of death (Item 23a) (Type, Print) THH min A Universite SISI

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	Physicia							Month 12/15		Year	5:45 P M
	Medic Examin		DORTS R. HARPER 4a. Facility Name (if not institution, give street)	and number)		4b. City, Town, or	Location of Death	12/12/		nty of Death	1 3 . 4 3 1
	Examili	eı	5605 S. Marwood Blvd		i	Upper Ma				ce_Geo	raels
	Funeral		Social Security Number 6. Sex	7. Age (In yrs. last	birthday)	If Under 1 Year	If Under 24 Hrs.	8. Date of Birth		9. Birthp	lace (State or Foreign
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Baltimore,	1 and of Heal item,		20a. Method of Disposition	20b. Plac	ce of Dispos	ition (Name of		Date		n - City or To	
Ë	Page nent c int: If iry or		1 ☐ Burial 2 ☐ Cremation 3 ☐ Remo	vai iloili otate		atory or other place National	· •	4/2009	\rlino	ton. V	Δ
altı	permit. Page 1 a Department of I Important: If ite any injury or of		21. Signature of Funeral Service Lice	1111111		Name and Address					
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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death Physician/ Month Medical 4b. City, Town, or Location of Death la. Facility Name (if not institution, give street 4c. County of **Examiner** NOSHING If Under 1 Year If Under 24 Hrs 7. Age (In yrs. last birthday) 8. Date of Birth g. Birthplace (State or Foreign Funeral (Month, Day, 1 X M 2 □ F Months Days Hours Maryland Jan. Director 20**-**28-3032 Usual Residence of Decedent 10b. County 10c. City, Town or Location 10d. Inside City Limits death with the Maryland Director iral", or items 23a or 28a-f s Examiner must be notified 1 X Yes 2 □ No Maryland Washington County Hagerstown 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 21740 U.S.A. 224 Division Ave. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian 12. Was Decedent Ever in U.S. 11. Marital Status Armed Forces 1 Never Married 2 Married þ 1 X Yes 2 No. If Yes, Give 195 Year or Dates. within 72 hours after Baltimore, Maryland 21215-0036 Specify: White 1 ☐ Yes 2 🕅 No Specify: "natural", Completed 3 Widowed 4 Divorced the Medical 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life, DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) Historical Maintenance Federal Government Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ٥ Helen Gould Byers Hicks Roscoe Herman Hicks 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 224 Division Ave. Hagerstown. Patricia A. Hicks-wife 20c. Location - City or Town, State 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 1 💢 Burial 2 🗆 Cremation 3 🗆 Removal from State Cedar LAwn Mem. Park 12-22-2009 | Hagerstown, Maryland 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licenses 22. Name and Address of Facility Douglas A. Fiery Funeral Home 1331 Eastern Blvd. North Hagerstown, Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respirato shock, or heart failure. List only one cause on each live. Approximate Interval Between Onset and Death Immediate Cause (Final WIC CEREBROVASCULOR Pnysician/ disease or condition resulting in death) Medical Due to (or, as a consequence of): Examiner UTENSION Sequentially list conditions, Examine if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury and -transit Hospital or Attending Physician: The law requires that the death certificate be executed that initiated events to (or as a consequence of) resulting in death) Last attending physician a for use as the burial-Physician/Medical Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ in the past 12 months? Day Month Year Pregnant at time of death in signed by the a 2 No Unknown g Unknown P.O. Part II. Other, significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☑ Unknown Division of Vital Records, Completed 24b. Were autopsy findings available prior to completion of cause of 24a. Was an cate has page 2 s autopsy death? 2 X No certificate Yes 25. Was case referred to medical examiner? 26. Place of Death (Check only one) director, Be Hospital Other: 1 🗌 Yes ည Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) this within 24 hours after ucco....

To the Funeral Director: After this 27. Manner of Diath Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred Certificate: injury work? Natural 5 Pending M 2 🗌 No Accident Investigation Suicide 3 Suicide 4 Homicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, determined City or Town, State Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check 3 Certifying Murse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 29c. License number 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

MARK BARAN MD, 251 E, DNT: Flori 2H11+ gistrar's Signature State

DHMH 17 Rev 7/2009

Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician LeRoy Holmes 2009 3:50 p December /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Carroll Westminster Carroll Hospital Center 8. Date of Birth (Month, Day, Year) NOV 19, 19 If Under 1 Year | If Under 24 Hrs. Social Security Number 6. Sex 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign Funeral Days Hours Months 1**X** M 2□ F Maryland 87 216-12-0713 1922 **Director** Usual Residence of Decedent Pages 1 and 2 should be filed within 72 hours after death with the Maryland 10c. City, Town or Location 10d. Inside City Limits 10a. State 23a or 28a-f show Examiner must be notified at Westminster 1 XYes 2 □ No Director Carroll Maryland 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 21158 416 Uniontown Road **USA** Funeral 14. Race - American Indian, Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Black, White, etc. 1 ☐ Never Married 2 Married ٥, Baltimore, Maryland 21215-0036 1 ☐ Yes 2 🛣 No Specify: white þ 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) pormit. Pages 1 and 2 should be filed within Department of Health and Mental Hygiene. Important: If Item 27 is marked other than 'any injury or other traumatic event, the Magnetic event, the Magnetic event, the Magnetic event. Elementary/Secondary (0-12) College (1-4or 5+) Hair Cutting Barber 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Carolyn Rothwell Grason Holmes 2 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 416 Uniontown Road, Westminster, MD 21158 19a. Informant's Name/Relationship (Type. Print) Miriam G. Holmes, wife 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 Burial 2 □ Cremation 3 □ Removal from State Evergreen Mem Gardens 12/18/2009 Finksburg, MD 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Myers-Durboraw Funeral Home 91 Willis Street, Westminster, MD 21157 Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death 23a. Part1 Immediate Cause (Final neumonia **Physician** disease or condition resulting in death) /Medical Due to **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner To the Hospital or Attending Physician: The law requires that the death certificate be executed physician and sthe burial-trans Division or Vital Records, P.O. Box 68760, Physician/Medical attending I IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Month in the past 12 months? Year Day 4☐Pregnant at time of death 5 ☐ Other (specify) ☐Yes 2☐No 9□Unknown 9 Unknown signed by 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. by 2 No 3 Probably 4 Unknown 1 TYes Completed 24b. Were autopsy findings available prior to completion of cause of death? 1 ☐ Yes 2 ☐ No 24a. Was an autopsy Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 Dinpatient P 2 ER/Outpatient 3 DOA After thi funeral 28a. Date of Injury (Month, Day Year) 27. Manner of Death 1 Natural 28b. Time of 28d. Describe how injury occurred 28c. Injury at Work? Certification: 5 ☐ Pending investigation 1 ☐ Yes 2 ☐ No within 24 hours after death. To the Funeral Director: A completely filled in by the f 2 Accident 6 ☐ Could not be 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifler Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) 29c. License number 51

State Registrar 31. Date filed (Month, Day,

Year

DHMH 17 Rev 1/2001

Name and address of person who completed cause of death (Item 23a) (Type, Print)

410

32. Beofstrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ HARRIS Month BRUCE 2009 8:27 PM December Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death Suburban Hospital Bethesda Montgomery 5. Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 6. Sex 8. Date of Birth (Month, Day, March 1 9. Birthplace (State or Foreign **Funeral** Day 1 Days 1 🕅 M 2 □ F Months Hours Min 223-52-0301 70 Director Virginia Usual Residence of Decedent 28a-f shov 10b. County than "natural", or items 23a or 28a-f sho the Medical Examiner must be notified at 10a. State 10c. City, Town or Location Director Maryland Montgomery Germantown 1 ☐ Yes 2 X No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 18747 Birds Eye Drive 20874 United States 72 hours after death 12. Was Decedent Ever in U.S. Armed Forces? 11. Marital Status Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. þ 1 Never Married 2 Married 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates. Baltimore, Maryland 21215-0036 1 ☐ Yes 2 😾 No Specify: 3 X Widowed 4 Divorced Specify: White Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Decedent's Education permit. Page 1 and 2 should be filed within 72? Department of Health and Mental Hygiene. Important: If ten 27 is marked other than "na any injury or other traumatic event "to once. 16b. Kind of Business Industry (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) Auto Repair Shop Owner Automotive Repair 8 Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Arnold Edward Harris Hazel MacClellan 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Marc A. Harris (Son) 12804 Atlantic Avenue, Rockville, MD 20851 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 ▼ Burial 2 □ Cremation 3 □ Removal from State 4 □ Donation 5 □ Other (Specify) Parklawn Memorial Pk. Rockville, MD 21. Signature of Funeral Service Lice 22. Name and Address of Facility DeVol Funeral Home IRAC 10 East Deer Park Dr. Gaithersburg, MD 20877 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line Immediate Cause (Final Onset and Death Ph sician/ disease or condition resulting in death) Acute Renal Failure Medical Due to (or as a consequence of): Examiner Respiratory Failure Sequentially list conditions if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Due to (or as a consequence or). Examir for use as the burial-trans that initiated events resulting in death) Last Due to (or as a consequence of): Completed by Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death
4 Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?
1 ☐ Yes 2 ☐ No 5 Other (specify) Month Dav Year the page 2 should be detached 9 Unknown 9 Unknown signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Cirrhosis of Liver 1 ☐ Yes 2 ☐XNo 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an this certificate has performed? Yes 2 X No Hospital or Attending Physician: The 24 hours after death. 1 🗌 Yes 2 🗎 No Be 25. Was case referred to medical funeral director, 26. Place of Death (Check only one) examiner? Hospital: 2 X No Other: မ 1 🗌 Yes 1 Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 4 Nursing Home 5 Residence 6 Other (Specify) 28a. Date of injury (Month, Day, Year) 27, Manner of Death Certificate: 28b. Time of 28c. Injury at work? 28d. Describe how injury occurred X Natural 5 Pendina Accident Investigation 1 Yes 2 No 3 ☐ Suicide 4 ☐ Homicide 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

within 24 hours a

DHMH 17 Rev 7/2009

State

Registrar

only one) 29b. Signature and tit

Dr. Atul

31. Date filed (Month, Day, Year)

DEC

Suburban Hospital

of person who completed cause of death (Item 23a) (Type, Print)

Registrar's Signature

Rohatgi M.D.

18

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated

70061302

29d. Date signed (Month, Day, Year)

20814

12/17

8600 Old Georgetown Rd./Bethesda, MD

Forthying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated

Amended Item 5 per F.D. 12/18/2009 Carroll County, will State of Maryland / Department of Health and Mental Hygiene 9 1 - For State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Physician Kenneth Roland Hommerbocker, Jr. 9:06 A M December 13 2009 /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death Examiner 2922 Blacks school House Road Taneytown Carroll If Under 24 Hrs. If Under 1 Year Months Days Birthplace (State or Foreign Country) 6. Sex 5. **214** Se76×0059 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) **Funeral** 1₩ 2□F Hours Min. Yrs. 215-76-0059 Mary land **Director** 50 May 30, 1959 Usual Residence of Decedent death with the Maryland 10c. City, Town or Location 10d. Inside City Limits 10a, State 10b. County ir than "natural", or Itams 23a or 28a-f show If a Medical Examiner must be notified at MD Carroll 1 ☐ Yes 2 X No Completed by Funeral Director Taneytown 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? USA 2922 Blacks School House Road <u> 21787</u> 12. Was Decedent Ever in U.S. Armed Forces?

1 ☐ Yes 2XX No
If Yes, Give
Year or Dates: 14. Race - American Indian, Black, White, etc. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Pueno Rican, etc.) Pages 1 and 2 should be filled within 72 hours after nent of Health and Mental Hygiene. and 1 item 27 is marked othar than "natural", or Ita 1 Never Married 2XX Married Baltimore, Maryland 21215-0036 1 Yes 2 No White Specify: 3 Widowed 4 Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business/Industry (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) Heavy Equipment Operator Construction 9 other traumatic avant, 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Kenneth Roland Hommerbocker, Sr. ပ္ Betty Marie Mills 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Linda Jean Hommerbocker/Wife 2922 Blacks School House Road, Taneytown, MD 21787 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 ☐ Burial 2 Cremation 3 ☐ Removal from State
4 ☐ Donation 5 ☐ Other (Specify) Department of Important: If any injury or once. = 5 Kenworthy Funeral Home, Inc. Dec. 16, 2009 Hanover, PA 21. Signature of Funeral Service Licensee 22. Name and Address of Facility 269 Frederick Street Kenworthy Funeral Home, Inc. Hanover, PA 17331 CC0354 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Betwee Onset and Dea RENAL DISEASE Immediate Cause (Final CHRONIC month **Physician** disease or condition resulting in death) /Medical Due to (or as a consequence of): **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Physician/Medical Examiner Due to (or as a consequence of) Hospital or Attanding Physician: The law requires that the death certificate be executed use as the burial-transit Due to (or as a consequence of): Box 68760, IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Year in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day 4☐Pregnant at time of death 5 Other (specify) P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, þ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ★Unknown the funeral director, page 2 should Be Completed 24a. Was an autopsy performed? 24b. Were autopsy findings available prior to completion of cause of death?

1 □ Yes 2 □ No 1 🗌 Yes 25. Was case referred to medicat examiner? 26. Place of Death (Check only one) Hospital: 1 ☐ Inpatient Cther: 4 Nursing Home Standarde 6 Other (Specify) Certification: To 1 Yes 2. No 2 ER/Outpatient 3 DOA 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 27. Manner of Death 28b. Time of 28d. Describe how injury occurred Natural 5 Pending after death. 1 ☐ Yes 2 ☐ No investigation 2 Accident 6 Could not be determined 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) filled in by 4 | Homicide 24 hours a Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

[2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical completely (Check only one) within 2 To tha tha 29b. Signature and title of certifier 2 WJL 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 10 LIPTHICUM, OPEKINGS DRIVE, TAPEYTOWP, MD WILLIAM 31. Date filed (Month, Day, Year) 32. Registrar's Signature State Registrar

State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death **Physician** 2009 A M December Walter Willis Johnston 0110 /Medical 4a. Facility Name (If not institution, give street and number) 4h. City. Town, or Location of Death 4c. County of Death **Examiner** Ceci1 E1kton Union Hospital If Under 1 Year If Under 24 Hrs. 8. Date of Birth
Mantha Days Hours Min. (Month, Day, 6. Sex 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) 5. Social Security Number **Funeral** 1 M 2 □ F Days July 8, 154-24-0472 74 Pennsylvania Director Usual Residence of Decedent filed within 72 hours after death with the Maryland 10d. Inside City Limits 10c. City, Town or Location 10a State 10h. County d other than "natural", or items 23a or 28a-f show event, I're Medical Examiner must be notified at 1 ☐ Yes 2 X No Director Maryland Ceci1 E1kton 10g, Citizen of What Country? 10e. Street and Number 10f. Zip Code 877 West Pulaski Highway 21921 United States Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14 Bace - American Indian Armed Forces?

1 MYes 2 □ No
If Yes, Give
Year or Dates: Black, White, etc. 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 □Yes 2 🗶 No Specify: þ Specify: 3 Widowed 4 Divorced White Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Automobile Mechanic Automobile Repair marked other 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) 2 should be fill and Mental H Be ၉ Walter Johnston Sara Abbott 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) S Department of Health a Important: If item 27 is any injury or other tra once. Winefred C. Johnston/Wife 877 W. Pulaski Highway, Elkton, MD 21921 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Pages 1 December 1 ☐ Burial 2 🗓 Cremation 3 ☐ Removal from State R. A. Ferris & Co., Inc. 25, 4 ☐ Donation 5 ☐ Other (Specify) 2009 West Chester, PA 22. Name and Address of Facility
Hicks Home for Funerals, P.A.
103 W. Stockton Street, Elkton, MD ature of Funeral Service Licensee 21921 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause pn each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** disease or condition resulting in death) /Medical Due to (or as a contequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease of Injury that initiated events Physician/Medical Examiner Due to (or as a consequence of) or Attending Physician: The law requires that the death certificate be execute physician and s the burial-trans resulting in death) Last Due to (or as a consequence of): attending ph for use as the IF FEMALE: 23c. If yes, outcome of pregnancy 23b. Was decedent pregnant 23d. Date of delivery 1 ☐ Live birth 2 ☐ Fetal death 4 ☐ Pregnant at time of death 3 Ectopic pregnancy in the past 12 months? Month Ye ar 5 Other (specify) P.0. s been signed by the should be detached 1 ☐Yes 2 ☐ No. 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, Completed by 1 ☐ Yes 2 ☐ No 3 Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an page 2 autopsy certificate I 2 X No 1 ☐ Yes 2 X No 1 ☐ Yes 25. Was case referred to medical examiner? funeral director Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 No 2 ER/Outpatient 3 DOA 1 Inpatient Certification: To this 28a. Date of Injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28d. Describe how injury occurred 28c. Injury at Work? After 1 1 Natural 2 Accident 5 Pending death. 1 ☐ Yes 2 ☐ No investigation within 24 hours after death

To the Funeral Director:
completely filled in by the f 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 - Homicide the Hospital 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation is prescribed at the time. Medical 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) 29c. License number ame and address of person who completed cause of death (Item 23a) (Type, Print) monson 31. Date filed (Month, Day, Year) 32. Registrar's Signature State JAN 0 7 2010 Registrar

DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. amend #10h Per FH G899 1/11/10 JH. State of Maryland 7 Department of Health and Mental Hygiene State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 20, Physician/ 2009 December Esther Violet Johnson 11:45 a.M Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death Asbury Solomons Nursing Center Calvert Solomons 5. Social Security Numbe If Under 1 Year If Under 24 Hrs. 8. Date of Birth . Age (In yrs. last birthday) 9. Birthplace (State or Foreign **Funeral** 1 🗆 M 2 🔯 Days Hours 09/29/192 Country)
Illinois Director 338-16-7915 88 Usual Residence of Decedent "natural", or items 23a or 28a-f show edical Examiner must be notified at 10a, State Calvert 10c. City, Town or Location 10d. Inside City Limits Director 1 Yes 2 No Maryland St. Mary's Solomons 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 11740 Asbury Circle, Apt. 1113 20688 United States 12. Was Decedent Ever in U.S. Armed Forces?
1 ☒ Yes 2 ☐ No If Yes, Give 11. Marital Status Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. þ 1 Never Married 2 X Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify. Specify: Completed 3 Divorced 4 Divorced Year or Dates White permit. Page 1 and 2 should be filed within 72 hour Department of Health and Mental Hyglene. Important: If item 27 is marked other than "naturany injury or other traumatic event, the Medical any injury or other traumatic event, the Medical 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) 12 Homemaker Own Home Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) မ John B. Facko Susan Halaj 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Edward S. Johnson/Husband 11740 Asbury Circle, Apt. 1113, Solomons, MD 20688 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 1 Burial 2 X Cremation 3 Removal from State d □ Donation 5 □ Other (Specify)

Signature of uneral Service Lidensee

Edward N. Brinsfield, Brinsfield-Echols Cre 12/24/2009 Charlotte Hall, MD 22. Name and Address of Facility Brinsfield Funeral Home, P.A. Jr. M00052 22955 Hollywood Road, Leonardtown, MD 20650 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Onset and Death Physician/ 4 NCREATIC MONTH Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury that initiated events resulting in death) Last Due to (or as a consequence oi). Physician/Medical Exami attending physician and for use as the burial-transit certificate be executed Due to (or as a consequence of): IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ____ in the past 12 months? Day 4 ☐ Pregnant at time of death 9 ☐ Unknown signed by the a d be detached f 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Completed 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an Jas autopsy performed? Yes 2 \(\textstyle{1}\) No certificate | 1 Yes 2 No 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner?
1 Yes 2 No Hospital Other: မ 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 4X Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) After this 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at work? Certificate: 28d. Describe how injury occurred To the Hospital or Attending 1 Natural 5 Pending injury n 24 hours after death.

• Funeral Director: Af pleted filled in by the fu 2 Accident
3 Suicide
4 Homicide 1 Yes 2 No Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number determined 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. (Check Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one) 29b. Signature and title of certifier 29c. License number

(10) prod

Box 68760

P.O.

Records,

Division of Vital

State Registrar

31. Date filed (Month, Day, Year) 32. Registrar's Signature

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

NEIDER

TOHN

FDPECK

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

			For State 12-22-09		aryland / Depa			Mental Hy		0 10650
			Registrar Amend#29d. 1. Decedent's Name (First, Middle, Le		Cor Ce	tificate of D	<i>Death</i>	2. Date of Dea	Reg. No. 2	7 36 1106
н	Physicia			,				Month Decemb	Day Ye	- M
	Medic Examin		Mosella 4a. Facility Name (if not institution, giv	Johnson re street and number)		4b. City, Town, or	Location of Death	ресешс	4c. County of E	
			Washington Adv	entist H	ospital	Takoma If Under 1 Year	Park		Montge	merv
	Funeral Director		· ·	Sex 7. Age 1 □ M 2 🔀 F	e (In ýrs. last birthday) 76 Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birt (Month, Da)	th y, Year)	Birthplace (State or Foreign Country)
			144-24-2781 Usual Residence of Decedent		76			IMay 2	6,1933	SC
	yland f sho	ctor	10a. State 10b. County		10c. City, Town or Lo	cation				10d. Inside City Limits
	e Mar r 28a- notifi	Dire	MD 10e. Street and Number	PG	Mou	nt Raini 10f. Zip Code	er		40 000 (1976)	1 X Yes 2 No
	vith th	rall	3305 Chauncey	Dlago #1	0.1		712		10g. Citizen of What	
	eath v tems er mu	Funeral Director	11. Marital Status	12. Was Decedent E	ver in U.S. 13.1	Was Decedent of His	spanic Origin? (Sp			American Indian,
36	ifter d ", or i	þ	1 X Never Married 2 Married	Armed Forces? 1 Yes 2 X If Yes, Give	No	f Yes, specify Cubar I □ Yes 2 🛣 No		Hican, etc.)		/hite, etc.
21215-0036	72 hours after death with the Maryland n "natural", or items 23a or 28a-f sho Aedical Examiner must be notified at	Completed	3 Widowed 4 Divorced 15. Decedent's	Year or Dates.		dent's Usual Occupa		_	Specify: B	
215	n 72 h an "na Media	lg II	(Specify only highest of Elementary/Seconday (0-12)		(Give	kind of work done d O NOT use retired)		ing	16b. Kind of Busine	ess industry
	led within I Hygiene. other than ent, the M		12			Healtho	are Nur	se	Privat	te
pue	be filed ental Hy rked oth ic event	To Be	17. Father's Name (First, Middle, Last,					_	Maiden Surname)	
Maryland	1 and 2 should be filed within 72 hours after death with the Maryland if Health and Mental Hygiene. item 27 is marked other than "natural", or items 23a or 28a-f show other traumatic event, the Medical Examiner must be notified at		Mose Johnson 19a. Informant's Name/Relationship		10h Maili	a Addrona /Stroot a	Surnato		. SON r, City or Town, State	Zin Codol
	and 2 sh Health ar tem 27 is		Lisha Thorne-H				andy Ar			, 2ip Code)
ore,	~ ~ ~ ~		20a. Method of Disposition 1 Burial 2 Cremation 3	_	20b. Place of Dispo	sition (Name of natory or other place	/	= 20 / 4 6 8 / 09	20c. Location - City	or Town, State
Baltimore,			4 ☐ Donation 5 ☐ Other (Spec	ify)	Harmony	Memoria	l Park	6/09	Landover	, Md
Ball	permit. Page Department Important: I any injury o		21. gnature of Funeral Service Lice	Owau	RIAI	Name and Addres	110		Edwards	F.H.
			23a. Part 1. Enter the disease, or cor shock, or heart failure. List only	nplications that caused one cause on each line	the death. Do not ente					Approximate Interval Between
Z	Pnysician/ Medical		mediate Cause (Final disease or condition resulting in death)	a. CAY	2DLAZ	DRRY.	TAMIR	ζ		Onset and Death
-	Examiner		resulting in death)	Due to (or as a	a consequence of):	Ceucili	(5 Pul	MINAR	4 DISTA	45
		ner	Sequentially list conditions, if any, leading to immediate		a consequence of):		700	×15 (0 /1-	1 200	
	outed nd ransit	Examiner	cause. Enter Underlying Cause (Disease or iinjury that initiated events	С.	EKTENS	10N				
0	ate be executed physician and the burial-transit	edical E	resulting in death) Last	Due to (or as a	a consequence of):	MELLIT	Y7 2U	DEM		
Box 68760	tificate ng phy as the		IF FEMALE:							
9 x 6	tth cer ttendii or use	ian/	23b. Was decedent pregnant in the past 12 months?	23c. If yes, outcome	2 Fetal death 3	Ectopic pregnancy	у		23d. Date of Month	delivery Day Year
B.	hat the death certific ed by the attending detached for use as	Physician/M	1 ☐ Yes 2 ☑ No 9 ☐ Unknown	4 ∐ Pregnant a 9 ☐ Unknown	time of death 5 L	Other (specify)				Day Tour
s, P.O.	Hospital or Attending Physician: The law requires that the death certificate be executed 24 hours after death. Funeral Director: After this certificate has been signed by the attending physician and sted filled in by the funeral director, page 2 should be detached for use as the burial-transi	by	Part II. Other significant conditions	CARCIN		nderlying cause give			1	e to the cause of death?
ord	requi	Completed	PNEUMO	NIA.				24a. Was a	an 24b. Were	autopsy findings available
3ec	The law ate has page 2	omo						autop perfo 1 Yes	rmed? deat	to completion of cause of h? Yes 2 Wo
ta	ysician: The is certificate director, pag	Be	25. Was case referred to medical examiner?				ace of Death (Chec		2210	
fVi	Physio this or	2	1 Yes 2 No	Hospital: 1 Inpatie	ent 2 ER/Outpatier 28b. Time of		4 □ Nursing Ho		dence 6 Other (S	pecify)
0 0	nding rth. : After	cate	1 Natural 5 ☐ Pending 2 ☐ Accident Investigation	(Month, Day		work	Yes 2 No	28d. Describe n	ow injury occurred	
Division of Vital Records,	To the Hospital or Attending Ph within 24 hours after death. To the Funeral Director: After th completed filled in by the funeral	Certificate:	3 Suicide 6 Could not 4 Homicide determined	be 280 Place of Inju	ry - At home, farm, str . (Specify)	eet, factory, office		28f. Location (S City or Tow		Rural Route Number,
۵	prital ours a eral D	calC	29a. Certifier 1 Certifying Ph	ysician: To the best of	my knowledge death	occured at the time	date and place ar	nd due to the car	use(s) and manner as	stated
	To the Hospital within 24 hours and To the Funeral Completed filled	Medical	(Check 2 Medical Exar	niner: On the basis of ex rse Practioner: To the	kamination and/or inves	tigation, In my opinio	n, death occurred a	t the time, date a	nd place, and due to t	the cause(s) and manner stated.
	vithi To th	-	29b. Signature and title of certifier	- 110		29c. License	number		29d. Date signed (M.	onth, Day, Year)
				m, MD.		D-C	201284		14/00(wou.
R	-3		30. Name and address of person who SHAMID SHAMIUNI	MD. MASH	THETON A	rint) VENT(ST	HOLP, TA	noma P	'ARK, HT	1-20912
	Stat Registra		31. Date filed (Month, Day, Year) DEC 2 2 2009	Registra	r's Signature					

DHMH 17 Rev 7/2009

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1 Decedent's Name (First Middle Last) 2. Date of Death Day **Physician** 14:35 PM 2009 a /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Mont gomer montgomer General Hospita If Under 1 Year | If Under 24 Hrs. Birthplace (State or Foreign Country) 5. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Funeral Days Months Hours 1 → M 2 □ F 57 Director 579-70-6542 HUNE 25 1952 WASHINGTON, DC Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits 28a-f show ortant; If item 27 is marked other than "natural", or items 23a or 28a-f shov injury or other traumatic event, the World Expression must be notified at 1 XYes 2 No Director SILVER SPRING MONTGOMERY MD 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number 20906 USA 2601 BELPRE ROAD Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☐ No 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian 11. Marital Status Black White etc. 1X Never Married 2 ☐ Married BLACK Baltimore, Maryland 21215-0036 If Yes, Give Year or Dates 1 □Yes 2 □ No Specify: Specify. 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) permit. Pages 1 and 2 should be filed within Department of Health and Mental Hygiene. Important: If item 27 is marked other than any injury or other traumatic event, In. In. College (1-4or 5+) NONE NONE 8th 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be DORIS HOLLAND T. JOHNSON WILBUR ပ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 10115 LINFORD TERRACE LANHAM, MARYLAND 20706 GOLDTRENA CARPENTER/SISTER 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 1 ☐XBurial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) LANDOVER, MARYLAND 12/26/2009 HARMONY CEMETERY 21. Signature of Fundamy Service Licensee J. B. JENKINS FUNERAL HOME 22. Name and Address of Facility 9 7474 LANDOVER ROAD LANDOVER, MARYLAND 20785 Approximate Interval Between Onset and Death 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) ute Myolardial **Physician** min /Medical Due to (or as a consequence of): Examiner neroscler IDVASCULAY DISEGSE Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examine Due to (or as a consequence of) The law requires that the death certificate be executed and burial-tra Due to (or as a consequence of): Box 68760, Physician/Medical attending properties for use as as IF FEMALE yes, outcome of pregnancy
☐ Live birth 2☐ Fetal death
☐ Pregnant at time of death 23d. Late of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Month Day Year 5 Other (specify) 1 ☐ Yes 2 ☐ No P.O. the 9 Unknown signed t Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Records, þ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an cate has I autopsy performed certificate Division of Vital 1 ☐ Yes 2 ☐ No 2 🗀 No or Attending Physician: 25. Was case referred to medical director Be 26. Place of Death (Check only one) 1 Yes 2 No Other: 4 \(\text{Nursing Home} \) 1 Residence 6 \(\text{Other} \) Other (Specify) 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To this 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of After t 28c. Injury at Work? 28d. Describe how injury occurred Injury 1 🗌 Naturai 5 Pending investigation within 24 hours after death.

To the Funeral Director: A completely filled in by the fi 2 Accident 3 ☐ Suicide 11/05/3005 17:00 PM 1 ☐ Yes 2 ☑ No by HIIIvehicle 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide 29a. Certifier Medical (Check only one) 29d. Date signed (Month, Day, Year)

State Registrar 29b. Signature and title of certifier

31. Date filed (Month, Day,

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Ker

29c. License number

0050410

Prince Philip Dr. Olney MID 20832

Med Dir

Dest EM

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Day Month FRANCIS LEE JACKSON rember 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number, HARLES ENTER AF LATA MEDICAL CIVISTA 9. Birthplace (State or Foreign If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 7. Age (In yrs. last birthday, 8. Date of Birth Days 1 ₹ M 2 □ F SEPTEMBER 19, 1938 MARYLAND 71 216-34-0632 Usual Residence of Decedent 10d. Inside City Limits 10a. State 10h County 10c. City, Town or Location Y⊈Yes 2 □ No MARYLAND CHARLES INDIAN HEAD 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code UNITED STATES 20640 111 THOMPSON LANE 12. Was Decedent Ever in U.S. Armed Forces? 1 M Yes 2 □ No If Yes, Give Year or Dates: 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 Never Married 2 Married 1 □Yes 2**X** No Specify: Specify: BLACK 3 Widowed 4 Divorced 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) 12TH GRADE College (1-4or 5+) PARCEL SORTER UNITED PARCEL SERVICE 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) ROSALEE DENT JACKSON HENRY TOTS JACKSON 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a, Informant's Name/Relationship (Type, Print) 111 THOMPSON LANE, INDIAN HEAD, MARYLAND 20640 RUTH JACKSON / WIFE 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20a. Method of Disposition 1X Burial 2 ☐ Cremation 3 ☐ Removal from State MARYLAND VETERANS CEMETERY DECEMBER 23, 2009 CHELTENHAM, MARYLAND 4 ☐ Donation 5 ☐ Other (Specify) 21. Strature of Fune all Service Licensee LYDIA C. THORNION JOHNSON M00583 THORNTON FUNERAL HOME, P.A. 3439 LIVINGSTON ROAD, INDIAN HEAD, MARYLAND 20640 Approximate Interval Between Onset and Death 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. one cause on each line. Immediate Cause (Final disease or condition resulting in death) S WK Due to (or as a consequence of): ERE V if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of Due to (or as a consequence of): 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Month Year in the past 12 months? Day 4 Pregnant at time of death 5 ☐ Other (specify) 1 ☐Yes 2 ☐ No 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown VASCUL 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an performed? 2 No 1 ☐ Yes 2 ☐ No 1 Tyes 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2'MoNo 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural 5 🗆 F

Physician /Medical Examiner

executed

requires that the death certificate be

P.O.

Records,

of Vital

Hospital or Attending

24 hours after deat Funeral Director:

within 2 To the !

filled in by

completely

permit. Pages 1 and 2 should be file Department of Health and Mental Hy Important: If item 27 is marked oth any Injury or other traumatic event

Physician

/Medical

Examiner

Director

Funeral

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Certification: To

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d other than "natural", or items 23a or 28a-f sho event, the Medical Examinar must be notified at

filed within 72 hours after

Maryland 21215-0036

Baltimoré.

burial-tra attending physician for the page 2 director, After

KENA

5 Pending investigation	
6 ☐ Could not be	

and manner stated.

28b. Time of Injury

1 ☐ Yes 2 ☐ No 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

(Check only one)

2 Accident

3 Suicide

29a. Certifier

4 ☐ Homicide

Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

| Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29d. Date signed (Month, Day, Year) 29c. License number

29b. Signature and title of certifie

30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 102 Paul

31. Date filed (Month, Day, Year)

32. Registrar's Signature

Mellon Ct. Suite 102 Waldorf Md 20602

State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Thomas David Kenney Medical 4a. Facility Name (if not institution, give street and number, 4b. City, Town, or Location of Death 4c. County of Death Examiner egani Medical egional impl
 If Under 1 Year
 If Under 24 Hrs.
 8. Date of Birth

 Months
 Days
 Hours
 Min.
 (Month, Day, Year)

 4-13-1927
 Social Security Number 6. Sex 7. Age (In yrs. last birthday, 9. Birthplace (State or Foreign **Funeral** Mary Land 1 XM 2 🗆 F 82 Director 216-22-7274 Usual Residence of Decedent permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once. 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director 1 Yes 2 No Mt. Savage Allegany 10f. Zip Code 10e. Street and Numbe 10g. Citizen of What Country? Funeral U.S.A. 21545 16020 Foundry Row NW 12. Was Decedent Ever in U.S.
Armed Forces?

1 X Yes 2 No 1945
If Yes, Give 1952 Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, et Completed by 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify: White 1952 Specify: 3 Widowed 4 Divorced Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) College (1-4 or 5+) Elementary/Seconday (0-12) Parts Associates Salesman Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Thomas W. Kenney Veronica Stole Kenney 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 16020 Foundry Row NW Mt. Savage, MD 21545 19a. Informant's Name/Relationship (Type, Print) wife Shirley Kenney 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Date 1 K Burial 2 Cremation 3 Removal from State 1-4-10 Rocky Gap Veterans Flinstone, MD 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Sowers Funeral Home, P.A. MOQ547. St Frostburg, 60 W. Main 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ disease or condition Medical resulting in death) Due to (or as a consequence of) **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury that initiated events Examiner Due to (or as a consequence of): Hospital or Attending Physician: The law requires that the death certificate be executed attending physician and for use as the burial-tran Due to (or as a consequence of): resulting in death) Last Physician/Medical Division of Vital Records, P.O. Box 68760 E FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?
1 ☐ Yes 2 ☐ No Month Day Year Pregnant at time of death 5 Other (specify) 9 Unknown been signed by should be detac Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 Tes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has autopsy performe within 24 hours after death.

To the Funeral Director, After this certificate 1 🗆 Yes 2 🗆 No funeral director, 25. Was case referred to medical 26. Place of Death (Check only one) Be examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 1 No 2 1 Inpatient 2 ER/Outpatient 3 DOA 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred Matural work' 5 Pending 1 🗌 Yes 2 🗌 No Accident Suicide Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 Homicide determined Medical 29a. Certifier 🔁 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 3 🗆 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one) 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) 29c, License number

State Registrar 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

DECEMBER 28, 2009

Cumberland MD 2/502

State of Maryland / Department of Health and Mental Hygiene Reg. No.2 () () 9 Certificate of Death 2. Dete of Deeth 1 Decedent's Name (First, Middle, Last, Month Dev Yeer **Physician** 12:58 2009 20 GARRIEL 2 /Medical 4b. City, Town, or Location of Deeth 4c. County of Deeth 4a Fecility Neme (If not institution, give street end number) Examiner Md PRINCE BOWIE HEARTH BOULIE If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Yeer) Birthplace (State or Foreign Country) 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) Funeral Days Hours 1□M 2□F Months Yrs. 437-74-1619 23 1948 Director 61 LOUISIANA Usuel Residence of Decedent Peges 1 end 2 should be filed within 72 hours efter death with the Merylend nent of Heatth end Mental Hygiene. Int: If Item 27 is merked other than "natural; or items 23s or 28s-f show 10d. Inside City Limits 10c. City. Town or Location 10a State 10b. County 1 □XYes 2 □ No Director MDPRINCE GEORGE'S BOWIE 10a. Citizen of Whet Country? 10e. Street end Number 10f. Zip Code 1211 DAVENTRY COURT 20721 USA Funeral 13. Was Decedent of Hispenic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U,S.
Armed Forces?
1 □XYes 2 □ No ARMY
If Yes, Give
Year or Dates: 14. Race - American Indian, Black, White, etc. 11 Marital Status 1 Never Married 2 X Married Baltimore, Maryland 21215-0020 1 ☐ Yes 2 ☐XNo Specify: Specify. BLACK ģ 3 Widowed 4 Divorced Be Completed 16a. Decedent's Usuel Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) College (1-4or 5+) Elementary/Secondary (0-12) 12TH LAW ENFORCEMENT GOVERNMENT 17. Father's Neme (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) GABRIEL KEYS SR. GRACIE PAUL 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) ALMETA R. KEYS/WIFE 1211 DAVENTRY COURT BOWIE, MARYLAND 20721

e of Disposition (Name of Date 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, cremetory or other place) 20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremetion 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Department of Important: If It ö 12/30/09 CHURCH CEMETERY JEANERETTE, LOUISIANA 21. Signature of Funeral Service Licenses 22. Name and Address of Facility J. B. JENKINS FUNERAL HOME 7474 LANDOVER ROAD LANDOVER, MARYLAND 23a. Part1. Enter the disease, or or mplicetions that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. and Death Physician Immediate Cause (Final disease or condition resulting in death) Atheroscherota vasular dispase /Medical Examiner Physiclan/Medical Examiner ettending physicien end for use as the buriel-transit or Attending Physician: The law requires that the death certificate be executed Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or es a consequence of) Division of Vital Records, P.O. Box 68760, that initieted events resulting in death) Last to (or as e consequence of) 23b. Did tobacco use contribute to the ceuse of death? Part II. Other eignificent conditions contributing to death but not resulting in the underlying cause given in Part I. 1 Yes 2 No 3 Probably 4 Unknown Be Completed by After this certificate hes been signe funeral director, page 2 should be r 24b. Were autopsy findings available prior to completion of cause of death? 24a. Wes an autopsy performed? a No 1 ☐ Yes 2 € No 1 Yes 25. Was case referred to medical 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Inpatient 2 ■ ER/Outpatient 3 ☐ DOA Medicai Certification: To 1 Yes 2 No 28a. Date of Injury (Month, Dey Year) 28c. Injury at Work? 27. Manner of Death 28b. Time of 28d. Describe how injury occurred 1 Natural 2 ☐ Accident 5 Pending 2 No investigation after death the 6 Could not be determined 3 Suicide 28e. Place of Injury · At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, Stete) ۵ 4 ☐ Homicide To the Hospital or within 24 hours at To the Funeral D 1 Certifying Physician: To the best of my knowledge, death occurred et the time, date and place, and due to the ceuse(s) and manner es steted.
2 Medical Examiner: On the basis of exemination end/or investigation, in my opinion, death occurred et the time, date and place, end due to the cause(s) and manner stated. 29a. Certifier (Check only one) 29d. Date signed (Month, Dev. Yeer) 29c. License number 29b. Signature and title of certifier DOUS1812 MD 30. Name end address of person who completed ceuse of deeth (Item 23e) (Type, Print) THOMAS 15001 LENIER 31. Dete filed (Month, Day, Year) 32. Registrer's Signeture State 3 2009

DHMH 16 Rev 6/95

Registrar

			for State Registrar	State	of Marylan	•	artmen rtificat			and M		giene Reg. No. 20	09	4265	7
	Dhusisi		1. Decedent's Name (First, Middle, Las	t)							2. Date of Dea Month	th Day_	Year	3. Time of Dear	
	Physici /Medic		Mary Elizabeth	Kunze							Month Decemb			4:20 a	М
	Examin	er	4a. Facility Name (If not institution, give			and in a		_	Location o	f Death		4c. Coun	ty of Death		
7			Gladys Spellman Specia 5. Social Security Number 6. Se		7. Age (In yrs.			verl	y If Under 2	24 Hrs.	8. Date of Birt	h		place (State or For	reian
	Funeral Director			M 25⊡ F	77	Yrs.	Months	Days	Hours	Min	(Month, Da)	v. Year)	Mary	place (State or For ntry) land	9
			Usual Residence of Decedent												
	nylan how	_	10a. State 10b. County		10c. Cit	ty, Town or Lo	cation							10d. Inside City Lir 1 ☐ Yes 2X	
	8a-f	cto		ntgome	ry	Sil	er S		g						,,,,,
	with the	Dir.	10e. Street and Number				10f. Zip					10g. Citizen o	wnat Cou	ntry ?	
	9ath v	Funeral Director	1614 Moffet Roa		edent Ever in U	S 13 V		903	isnanic Orio	rin2 (Sne		USA 14. B	ace - Ameri	can Indian.	
	fer d	Fun	11. Marital Status 1 ☐ Never Married 2 ☐ Married	Armed F		1				Puerto	cify Yes or No- Rican, etc.)	В	lack, White,	etc.	
9	within 72 hours after death with the Maryland ene. then "patural", or Items 23s or 28s-f show the Medical Examiner must be notified at	ρ	3 € Widowed 4 □ Divorced	If Yes, G Year or	ive Dates:		1 🗌 Yes	2 🔀 No	Specify:			Spec	^{;ify:} Whj.	te	
5-0036	72 ho	Completed	15. Decedent's Ed (Specify only highest gra	ucation	}	16a. Dece	kind of wo	rk done d	turina most	t of worki	ng	16b. Kind of			
2121	ithin	m jd	Elementary/Secondary (0-12)		(1-4or 5+)	life.	DO NOT u	se retired) ramme			Cath	olic	Church	
7	led w tygier her ti	S	1.2 17. Father's Name (First, Middle, Last)			Compe	TLEI .	109.			(First, Middle,				
auc	intal herinal	o Be	Henry Oldewurtel								Nelson	maraon barr	2		
Maryland	should mark mark	ř	19a, Informant's Name/Relationship (7	ype, Print)		19b. Mailir	ng Address	(Street a	and Numbe	er or Rura	l Route Numbe	er, City or Tow	n, State, Zi	Code)	
S	alth al		Lawrence Edward K	unze/S	on	3305	Velv	et V	all.ey	Dri	ve, Wes	t Frie	ndshi	p, MD 21	794
ē,	of Hern Item		20a. Method of Disposition		20b. I	Place of Dispo	sition (Name	ne of ther plac	9)		ec. 18	20c. Location	ı - City or T	own, State	
altimore,	Page nent c int: If		1X Burial 2 ☐ Cremation 3 ☐ 4 ☐ Donation 5 ☐ Other (Specify		Ga	te of I	leave	n Ce	meter	У	2009	Silve	r Spr	ing,Mary	lan
Balt	permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Department of Health and Mental Hygiene Tratural: or Itema 23a or 28a-f show Important: If Item 27 is marked other than "natural", or Itema 23a or 28a-f show any Injury or other traumatic event, the Medical Exam per must be notified at ODGs.		21. Signature of Funeral Service Licen	7 Col	L	F1	Name ar Sanci O Un	nd Addres s J. iver	s of Facilit Coll Sity	ins Bl v d	Funeral	Home ilver	Inc Sprin	g, MD 20	901
			23a. Part1. Enter the disease, or company shock, or heart failure. List only	lications that	caused the deal	th. Do not ent	er the mod	le of dyin	g, such as	cardiac o	r respiratory ar	rest.		Approximate Interval Between	
,	Physician		Immediate Cause (Final disease or condition		RIOSCU						_			Onset and Death	n
	/Medical Examiner		resulting in death)		(or as a consec										
	LAGITITICI	J.	Sequentially list conditions, if any, leading to immediate	b. Due to	(or as a consec	mence of):								·	
	red nsit	Examiner	cause. Enter Underlying Cause (Disease or injury	56510	(01 43 4 0011300	(40/100/01).									
· ·	execun n and ial-tra	Exar	that initiated events resulting in death) Last	C. Due to	(or as a consec	quence of):									
760,	Attending Physician: The law requires that the death certificate be executed in death. sctor: After this certificete has been signed by the attending physicien and by the funeral director, page 2 should be detached for use as the burial-transit.	icai		d											
89	ng phy as th	ed	IE ECHALC:				· · · · · · · · · · · · · · · · · · ·				-				
Вох	eath certific attending p	Physician/M	IF FEMALE: 23b. Was decedent pregnant		utcome of pregn birth 2 🗌 Feta		∃Ectopic p	regnancy					Date of delive	rery Day Year	
P.O.	the al	/sici	in the past 12 months? 1 ☐ Yes 2 No 9 ☐ Unknown	4∏Preg 9∏Unk	inant at time of one of the second of the se	death 5⊡	Other (sp	pecify)							
٣.	that the ed by detac		Part II. Other significant conditions or	ontributing to	death but not res	sulting in the u	nderlying	ause give	en in Part I.		23e. Did t	obacco use co	ontribute to	the cause of death	1?
Records,	uires that the dei signed by the a Id be detached f	d by	RESPIRATORY FA	LURG	VENTI	LATUR	DEF	ENZ	SENIE	معقع	10	∕es 2□No	3 ☐ Pro	bably 4 🔀 Unkn	nown
Ö	w require been si should b	iete	CHRONIC Obstru								24a. Was	an 24	. Were aut	opsy findings avail	lable
Be	sician: The law certificete has b irector, page 2 s	Completed	CEREBRAL INFA		•	COL	,				autor perfo	rmed?	prior to co death? 1 ☐ Yes	ompletion of cause 2□ No	a of
ta	an: rtifice tor, p	BeC	25. Was case referred to medical	RCTIO	y				26. Place	of Death	(Check only o			20,10	
>	ysici nis ce direc	ToE	examiner? 1 □ Yes 2 🛣 No	Hospital: 1	Inpatient 2	ER/Outpatier	nt 3 DO	OA Oth	er: 4 ∑ Nu	ırsing Ho	me 5 ☐ Resi	dence 6 🗆 🤇	ther (Spec	(y)	
0	fter th		27. Manner of Death 1 ☑Natural 5 ☐ Pending	28a. Date (Mo	of Injury oth, Day Year)	28b. Time o Injury	f 2	28c. Injun Worl			28d. Describe I				
Sio	uttendi death. ctor: A y the fu	cati	2 Accident investigation 3 Suicide 6 Could not be				М		Yes 2 🗍	-					
Division of Vital	I or Attending Physicien: The I after death. Director: After this certificete ha I in by the funeral director, page	Certification:	4 Homicide determined	280. Plac	e of Injury · At h ding, etc. (Speci	ome, farm, sti fy)	reet, factor	y, office			City or Tou		noer or Hui	al Route Number,	
_	To the Hospital or A within 24 hours after To the Funeral Dire completely filled in b		29a. Certifier 1 Certifying Ph												
	the H nin 24 the Fi	Medicai	one)	and ma	nner stated.	and and of In				an occurr	ou at the time,				
•		~	29b. Signature and title of certifier	17.		0			e number	-	,	29d. Date sig			
	8		Lantein	Ulli	re m	<u> </u>	0.00		4	5 2	'	UTCEN	IBER	15 200	9
			30. Name and address of person who	completed car	ise of death (Ite	m 23a) (Type,	Print)		0	1 Hz	67151	11/2 /	ui)	15200 2078	
	Sta	ite	31. Date filed (Month, Day, Year)	32.	Registrar's Sign	attito		UN	4 00	,,,,,,		,,,,,		77.	
	Registr		DFC 17 200	9 /2	min 1	he	Made.								

DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible AMEND TIEM#10e, 17,18,19a, b, #22perHosp. g 900, 275 / 2910, WS State of Maryland / Department of Health and Mental Hygiene?

42658 1 - For State Registrar Certificate of Death Reg. No. 2. Date of Death 1. Decedent's Name (First, Middle, Last) 3. Time of Death Month 12 **Physician** 23 8:30 p 2009 /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death Examiner SHADY GROVE ADVENTIST HOSPITAL If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country)
 MARYLAND 5. Social Security Number 7. Age (In yrs. last birthday) 6 Sax **Funeral** 57 1 ☐ M 2 XF Months Days Hours Yrs. Director NONE Usual Residence of Decedent with the Maryland 10d. Inside City Limits 10a State 10b. County 10c. City, Town or Location 28e-f show item 27 is marked other then "naturel", or Items 23a or 28e-f show other treumatic event, the Neuleal Examinating at ROCKVILLE, 1 Yes 2 □ No Completed by Funeral Director MONTGOMERY MARYLAND 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? USA FALLSGROVE KOAD NW 20850 #5023 Pages 1 and 2 should be filed within 72 hours after death nent of Health and Mental Hygiene. int: If item 27 is marked other then "naturel", or Items 23 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 IVNo If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1□ Yes 2 No Specify: OTHER Specify ASIAN 3 Widowed 4 Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) NFANT INFANT 18. Mother's Name (First, Middle, Maiden Sumarre) 17. Father's Man (Eirst, Middle, Last) Be BIMANTARA FEBRIYANTHI 2 Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City, or Town, State, Zip Code) ROAD NW FALLSGROVE MANTARA HATHER ROCKVILLE, MD 20850 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) ò STERI Department of importent: If any injury or once. CYCLE 01 25 2010 RIVER 4 Donation 21. Signature of Funeral Service License Rockville, Md. 20850 22. Name and Address of Facility 9901 MEDICAL CENTER DRIVE Approximate Interval Between Onset and Death 23a. Part1. Enter the disease shock, or heart failure. (L mplications that caused y one cause on each line e death. Do not enter the mode of dying, such as cardiac or respiratory arrest, List or Immediate Cause (Final disease or condition resulting in death) **Physician** orematu /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Physician/Medical Examiner Due to (or as a consequence of) as the burial-transit Hospitel or Attending Physician: The law requires that the death certificate be executed Due to (or as a consequence of): Box 68760 IF FEMALE: esn If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 DEctopic pregnancy ò in the past 12 months?
1 Yes 2 No Year Month Day 4☐ Pregnant at time of death 5 Other (specify) P.0. be detached 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, γ 2 No 3 Probably 1 🗌 Yes 4 Unknown Be Completed the funeral director, page 2 should 24b. Were autopsy findings available prior to completion of cause of death?

1 Yes 2 No 24a. Was an autopsy performed2 1 Yes PX 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: 1x Inpatient Cther: 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 2 X No Medicai Certification: To 1 Yes 2 ER/Outpatient 3□ DOA 27. Manner of Death
1 Natural
2 Accident Date of Injury (Month, Day Year) 28d. Describe how injury occurred 28b. Time of 28c. Injury at Work? After 5 Pending investigation Injury 2 🗌 No 1 Yes death. after death 3 🗌 Suicide 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined filled in by 4 🗍 Homicide 24 hours a Descrifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

| Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier completely and manner stated within 2 the 29d. Date signed (Month, Day, Year) 29b. Signature and title of 29c. License number 9 D58033 2009 completed cause of death (Item 23a) (Type, Print) DRIVE ROCKVILLE, MARYLAND MEDICAL COUTER HNDERS 9901

State Registrar

	10065 frey Lawrenc		•		or Print in of Maryla	nd / Dep	oartm	ent of	Hea	alth an				egibl		10	1.2650	2
			1- For State Registrar			Ce	ertific	ate of I	Dea	ath				Reg. No	201	צו	42659	2
Me	Physici dical Exami		1. Decedent's Name (First, Midd J	_{dle,Last} effi		awrence	e	Kaufm	nan				2. Date of De Month Decemb		2009 Year		3. Time of Death 0926 hrs	
			4a. Facility Name (if not instituti 1831 Hatfield Road	on, give	e street and num	nber)		46		, Town, or		of Death			c. County of		Calvert	_
	Funeral Director		5. Social Security Number	6. Se		7. Age (In yrs.	. last birt	thday)	If Un	nder 1 Yea	_		1	,	ĺ	Foreig	thplace (State or	-
	Director		217-04-9537 Usual Residence of Decedent	1 X	M 2 F	35	,	Yrs.	N.C.	1010	3		04-11	19	74	Co	untry)Maryland	1
	id how any Ee,		10a. State 10b. County	1vei		10c. Cit	ty, Town	or Location		nting	+0.40						10d. Inside City Limits 1 Yes 2 X No	
)	Dre, MD 21215-0036 ss I and 2 should be filed within 72 hours after death with the Maryland of Health and Mental Hygiene. If item 27 is marked other tt.an "natural", or items 23a or 28a-f show her traumatic event, the Medical Examiner, must be notified at once.	Director	10e. Street and Number							ip Code				10g. Ci	itizen of W ha		itry?	_
	with the ns 23a o be notifi	ral Di	1838 Hatfield 11. Marital Status		12. Was Dece		U.S.	13. Was	Dece	dent of His)639 spanic Ori	igin? (Spe	ecify Yes or N	No-		Americ	can Indian, Black,	_
	ter death ", or iter	Funeral	1 Never Married 2 X N 3 Widowed 4 Div		Armed For- 1 Yes If Yes, Give Year	2 X No		If Yes	s, spec	cify Cuban	n, Mexicar	n, Puerto R	Rican, etc.)		White,			
	hours afi 'natural Examin	ted by	15. Decedent's Education (Spe	ecify on	Lor Dates: nly highest grade	e completed)		Decedent's during mos	s Usua	al Occupat	tion (Give	kind of wo		16b.	Kind of Busi	whi		_
	oithin 72 ene. er than *	Completed	Elementary/Secondary (0-12)		College (1-4	4 or 5+)	1	nion e						e1	ectri	c c	onstruction	n
	imore, MD 21215-0036 Pages I and 2 should be filed within 72 hours after ment of Health and Mental Hygiene. tant: If item 27 is marked other than "natural", or other traumatic event, the Medical Examiner.	Be င၀	17. Father's Name (First, Middle James Eugen		Kaufmar	n					18.Mother	•	First, Middle Cather		n Surname) Snyo	der		_
	MD 21; d 2 should b th and Men n 27 is mar umatic eve		19a. Informant's Name/Relations	ship (Ty	ype, Print)		- 1					mber or Ru	ıral Route Nu	umber, C	City or Town,			-
3	Baltimore, M permit. Pages 1 and 2 Department of Health Important: If item 2 injury or other traun	1	Trudy Nicole Ka 20a. Method of Disposition 1 X Burial 2 Cremation			20b.	o. Place o	of Dispositions of Disposition	on (Na	ame of cen			Date		1, MD 2 Location - C			_
	Baltimore, permit. Pages I ar Department of Hee Important: If iter injury or other tr		4 Donation 5 Other S 21. Signature of Funeral Service	pecify:			nesa	peake		ighlan						_	olic, MD	_
			William	R	.Cho	~~		832	25 1	Mt. H	larmo	ny La	ane, O	wing	ral Hom gs, MD	20	736	
	Physician /Medical		23a. Part I. Enter the disease, or failure. List only one cause Immediate Cause (Final disease	on eac					mode	of dying,	such as c	ardiac or r	espiratory a	rrest, she	ock, or heart	i	Approximate Interval Between Onset and Death	
	Examiner		or condition resulting in death)	в а. <u> </u>	Due to (or as a o	consequence	of):	La										-
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	6876/ ertificate iding phy se as the l		IF FEMALE: 23b. Was decedent pregnant in the past 12 months?	ne	23c. If yes, ou	rth	2		death		Ectopic	c pregnand	Э	23	d. Date of de Month	elivery Da	ay Year	
	Box ie death c the atter	hysic		known	9 Unknow		5		r (Spe						· · · · · · · · · · · · · · · · · · ·			
	P.O.	è	Part II. Other significant condit	ions	contributing to d	leath but not	resulting	in the und	lerlyin	ig cause gi	iven in Pa	art I.				_	ne cause of death? ably 4 Unknown	
	ords, aw requir	Completed										_	24a. Was	opsy	pric	or to co	opsy findings available ompletion of cause of	-
	Rec The k		25. Was case referred to medica	<u> </u>						26 Place	of Death	(Check on	1 🗸 Yes	formed?		eth? Yes	2 No	_
	Vita hysician this cer	ě	examiner? 1 ✓ Yes 2 No		ospital: 1 Inp	patient 2	ER/OL	utpatient 3			Other	Nursing		Reside	ence 6 🗸	Other:	Scene	_
	on of anding P ath. or: After	tion:	27. Manner of Death 1 X Natural 5 Pend			f Injury Day,Year)	28b. T	Time of Inju	ry		ry at Work res 2	? 28 No	8d. Describe	how inju	ury occurred			
	Division of Vital Records, P.O. Box 68760, To the Hospital or Attending Physician: The law requires that the death certificate be execut within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial - tra	Certification:	3 Suicide 6 Coul	stigation Id not be rmined	28e. Place o	of Injury - At h	home, fa	rm, street,	factor)	y, office bu	uilding, et	c. 28	8f. Location or Town,		and Number o	or Rura	al Route Number, City	-
	the Hosp in 24 hou the Fune pletely fi	ल	29a. Certifier 1 Certifying Pl		an: To the best o		_											
_	To to To com	Med	29b. Signature and title of certifie	į į	and manner stat					c. License					Date signed			-

31. Date filed (Month, Day, Year) State Registrar

Assistant Medical Examiner 111 Penn Street, Baltimore, MD 21201

ORIGINAL

O.C.M.E.

1. Offgrute The Young
30. Name and address of person who completed cause of death (Item 23a)

Margarita Korell MD.

December 26, 2009

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First Middle Last) 2. Date of Death 26,2009 **Physician** DEC. 11:57A™ EARL DONALD LANHAM, SR. /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death **Examiner** 6900 MAXWELL DRIVE HUGHESVILLE CHARLES If Under 1 Year | If Under 24 Hrs. 9. Birthplace (State or Foreign WASH*, D.C 5. Social Security Number 8. Date of Birth 10-19-1929 **Funeral** 6. Sex 7. Age (In yrs. last birthday) Months Min. Days 1 € M 2 □ F 80 577-32-0303 Director Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits 28a-f show 2 should be filed within 72 hours after death with the Maryla is and Mental Hygiene. is marked other than "natural", or items 23a or 28a-f shov raumatic event, I'm Modeal Examire mant be notified at HUGHESVILLE 1 ☐ Yes 2 XNo MD. CHARLES Director 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 6900 MAXWELL DRIVE 20637 U.S.A. Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☐ No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 ☐ Never Married 2 Married Baltimore, Maryland 21215-0036 þ 1 ☐ Yes 2 🔯 No SpecifWHITE 3 Widowed 4 Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) WOOD WIRE METAL METAL LATHER 9th <u>LATHER LOCAL 9</u> 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) es 1 and 2 should be fil of Health and Mental H Fitem 27 is marked of Be RICHARD BURNS LANHAM HARRIET HAGER other traumatic ပ္ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 6900 MAXWELL DRIVE HUGHESVILLE, MD. 20637 MARY LANHAM-SPOUSE permit. Pages 1 a Department of He Important: If item any Injury or othe 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State M☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) CEDAR HILL CEMETERY 12-31-09 SUITLAND, MD. 21. Signature of Funeral Service Licenses M00479 22. Name and Address of Facility RAYMOND FUNERAL SERVICE, P.A. Mulio PLATA, MD. 20646 23a. Part1. Enter the disease, or complications that caused the death. shock, or heart failure. List only one cause in each line. Approximate Interval Between Onset and Death Do not enter the mode of dying, such as cardiac or respiratory arrest, Immediate Cause (Final disease or condition resulting in death) **Physician** /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any leading to firm a late cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Drie to for as a consequence offi The law requires that the death certificate be executed burial-transit and Due to (or as a consequence of): physician Physician/Medical the attending pl IF FEMALE: yes, outcome of pregnancy ☐ Live birth 2☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 □ Yes 2 □ No Day Year Pregnant at time of death 5 Other (specify) the 9 Unknown ģ s been signed he should be deta Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an cate has l page 2 s autopsy performed certificate 1 □Yes 2 No director, 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA this Certification: To 28a. Date of Injury (Month, Day, Year) 27. Manner of De th 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural 2 Accident 5 Pending investigation 1 ☐ Yes 2 ☐ No

Box 68760, P.0. Division of Vital Records,

After th funeral To the Hospital or Attending Pleatin 24 hours after death.
To the Funeral Director: After the completely filled in by the funeral

Medical

State

31. Date filed (Month, Day, Year) Registrar

3 Suicide

29a, Certifier

4 ☐ Homicide

(Check only one)

29b. Signature and title of certifier



30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

6 Could not be

determined

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

0

Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29c. License number

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29d. Date signed (Month, Day, Year)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 42661 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Year Month 6737 arah Medical a 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Regional Med Center Allegany

9. Bitthplace State or Foreign Western Md. mberlan 5. Social Security Number 8. Date of Birth (Month, Day, Year) 12-4-1924 Funeral 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 1 M 2 🔀 F MARYLAND Director 218-12-5490 Usual Residence of Decedent permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-1 show any injury or other traumatic event than "natural". 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director 1 X Yes 2 No ALLEGANY FROSTBURG 10f. Zip Code 10g, Citizen of What Country? Funeral 21532 100 HONEYSUCKLE LANE APT 420 U.S.A. 12. Was Decedent Ever in U.S. Armed Forces?

1 Yes 2 No If Yes, Give Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian. Black, White, etc. þ 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify: 3 ™ Widowed 4 □ Divorced Specify: Completed WHITE Year or Dates 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) OWN_HOME 10 <u>HOMEMAKER</u> Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ပ္ CHARLES SEGGIE PEARL WHITEHEAD SEGGIE 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 11310 BLAN AVON ROAD FROSTBURG, MD 21532 DIANA CUTTER DAUGHTER 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date cemetery, crematory or other place) 1 Burial 2 ☐ Cremation 3 ☐ Removal from State FROSTBURG MEM PARK 4 ☐ Donation 5 ☐ Other (Specify) 12-29-2009 FROSTBURG, MD 21. Signature of Funeral Service Licensee 60 W MAIN ST FROSTBURG MD 21532 Sowed 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition)

OBSTRUCTIVE JAUNDICE Approximate Interval Between Onset and Death Pmysician/) Medical resulting in death) Due to (or as a consequence of) Examiner Sequentially liet conditions, if any, leading to immediate cause. Enter Underlying Examine Due to (or as a consequence of) attending physician and for use as the burial-transi Cause (Disease or iinjury that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ in the past 12 months? Month Dav Year 1 Yes 2 No 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 Yes 2 No 3 Probably 4 Unknown Completed within 24 hours after death.

To the Funeral Director: After this certificate has been si completed filled in by the funeral director, page 2 should I 24b. Were autopsy findings available prior to completion of cause of death? autopsy perform the Hospital or Attending Physician: 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 No 1 Yes 1

Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred Natural Accident 5 Pending work?
1 Yes 2 \square No Investigation 6 Could not be Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide City or Town, State) Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. (Check Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certifier OECEMBER 25,2009 DZ6907 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Registrar
DHMH 17 Rev 7/2009

32. Registrar' Signat

09-09805 Joseph Lacev

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

озерп цасеу		1- For State Critificate of Death		200	0 1000
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Physici. Medical Exami	2111/		Month December		1410 hrs
modrodi Exam.		Joseph Gerald Lacey 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death		4c. County of Dea	
		VA Hospital Baltimore			
Funeral		·	. 8. Date of Birth	(MM/DD/YYYY) 9. B	irthplace (State or Foreign
Director		Months Days Hours Min.		C	ountry)
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any		10a. State 10b. County 10c. City, Town or Location			10d. Inside City Limits
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laryland 8a-f show at once.	용	Maryland St. Mary's California 10e. Street and Number 10f. Zip Code	100	g. Citizen of What Co	untry?
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vith the s 23a s 23a	<u>=</u>	22003 Park Drive 20619 11. Marital Status 20619 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Sp		nited Stat	rican Indian, Black,
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e, MD 21215-0036 I and 2 should be filed within 72 hours after death with the Maryland Health and Mental Hygiene. Fitem 27 is marked other than "natural", or items 23a or 28a-f shorr traumatic event, the Medical Examiner must be notified at once		Mary Anne Trevino/Sister 22003 Park Drive, Cal	ifornia,	MD 20619	
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alti rmit. spartri port jury	- 1	21. Signature of Funeral Service Licensee 22. Name and Address of Facility Brin	nsfield	Funeral Ho	ome, P.A.
00 80 5 5 5		Kyle S. Simons M01206 [22955 Hollywood Roa	ad, Leon	ardtown, N	<u>1D 20650</u>
Physician		23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac of failure. List only one cause on each line.	r respiratory arres	st, shock, or heart	Approximate Interval Between Onset and
/Medical Examiner		Immediate Cause (Final disease a Hypertensive Atherosclerotic Cardiovascular Disease			Death
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Box 687 e death certificathe attending pleed for use as the	Physician/	past 12 months? 1 Live birth 2 Fetal death 3 Ectopic pregnate at time of death 5 Other (Specify)	ancy	Month	Day Year
BOy death	ıysi	1 Yes 2 No 9 Unknown 9 Unknown			
O. Bat the da I by the tached I		Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.	23e. Did tob	acco use contribute	to the cause of death?
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Division of Vital Records, ral or Attending Physician: The law requirers after death. al Director: After this certificate has been sided in by the funeral director, page 2 should be	Certification:	1 Natural 5 Pending (Month, Day, Year) 1 Yes 2 No		• •	
ivision or Atteno ifter death Director:	<u>i</u>	2 Accident Investigation 28e. Place of Injury - At home, farm, street, factory, office building, etc.	28f. Location (St	treet and Number or I	Rural Route Number, City
Div talor safter led in	틠	Suicide 4 Homicide Gould not be determined (Specify)	or Town, Sta		
Hospital 24 hours Funeral tely fille		29a. Certifier	due to the cause	e(s) and manner as st	ated.
Division of Vital Records, P.O. Box 68760, within 24 hours after death. To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial - transi	Medical	one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred a			
To con	Me	and manner stated. 29b. Signature and title of certifier 29c. License number		29d. Date signed (A	fonth, Day, Year)
A		O.C.M.E.		December 18,	2009
ر القولي		30. Name and address of person who completed cause of/death (Item 23a)			
Scripe		Zabiullah Ali, M.D. Assistant Medical Examiner 111 Penn Street, Baltimore, MD 21	201		
	ate	31. Date filed (Month, Day, Year) 32. Registrar's Signature			
	trar	155 22 2009 Breez A. Sorke			

Drivin 17 Rev 1/2001 OCME 2006

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygien 200State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month 2009 <u>December</u> 8:30 <u>Evelyn</u> Althea a 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death 21811 Milton Lane Lexington Park St. Mary's 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth Birthplace (State or Foreign Country) Hours 1 M 2 TO F 04/22/1916 Maryland 212-38-3445 93 Usual Residence of Decedent 10b. County 10c. City, Town or Location 10d. Inside City Limits 1 Yes 2 No Maryland St. Mary's Lexington Park 10e. Street and Number 10g. Citizen of What Country? 21811 Milton Lane 20653 USA 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 12. Was Decedent Ever in U.S. 14. Race - American Indian. Armed Forces Black. White, etc. 1 Never Married 2 Married 1 Yes : 2 X No 1 ☐ Yes 2 K No Specify: 3 X Widowed 4 ☐ Divorced White Year or Dates 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) Own Home 12 Homemaker 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Esther Jones Mosher Lida Pau1 Joy 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) J. Daniel Simpson/Grandson 21685 Cambria Street, Lexington Park, MD 20653 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State cemetery, crematory or other place) 4 ☐ Donation 5 ☐ Other (Specify) Ebenezer Cemetery 12/31/2009 Lexington Park, MD 21. Signature of Funeral Service Licenses 22. Name and Address of Facility Brinsfield Funeral Home, P.A. Shawn Aylesworth M0152922955 Hollywood Rd., Leonardtown, MD 20650 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Immediate Cause (Final resulting in death) Due to (or as a consequence of) Due to (or as a consequence of): 23d. Date of delivery 3 Ectopic pregnancy
5 Other (specify) in the past 12 months?
1 Yes 2 No Pregnant at time of death 9 Unknown

Physician/ Medical **Examiner**

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After this certificate

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Certificate:

Medical

To the Hospital or Attending Physician: within 24 hours after death.

To the Funeral Director: After this certific completed filled in by the funeral director,

The law requires that the death certificate be executed

Division of Vital Records, P.O. Box 68760

Physician/

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Page 1 and 2 should be filed within 72 hours after death with the Maryland

Baltimore, Maryland 21215-0036

Sequentially list conditions, if any, leading to inninediate cause. Enter Underlying Cause (Disease or linjury that initiated events Exami resulting in death) Last Physician/Medical IF FEMALE: 23b. Was decedent pregnant 9 Unknown þ Completed

to death but not resulting in the underlying cause given in Part I.

23e. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 Ø No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an

1 Yes 2 No

25. Wa ase ref Hospital: 2 No 1 Yes 1 Inpatient 2 ER/Outpatient 3 DOA

determined

26. Place of Death (Check only one) 4 Nursing Home 5 Residence 6 Other (Specify)

27. Manner of Death **Natural** 5 Pending 2 Accident
3 Suicide Investigation 6 Could not be

28a. Date of injury (Month, Day, Year) 28b. Time of injury 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28c. Injury at work? 28d. Describe how injury occurred 1 ☐ Yes 2 ☐ No

28f. Location (Street and Number or Rural Route Number,

autopsy

Yes 2 No

29a. Certifier (Check

4 Homicide

💆 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of c

29c. License number

cause of death (Item 23a) (Type, Print) 30. Name and address of person who complete

> P. 24035 Three Notch Rd., Hollywood, MD 20636 James Jarboe M.D.

31. Date filed (Month,

32. Registra 's Signature

Registrar

		For State Registrar	State o	f Maryla	nd / Depa	artmen			and N	Mental H	ygien Reg. 1	2	009	42664
	Ţ,	Decedent's Name (First, Middle)	Last)							2. Date of D	eath			3. Time of Death
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permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.		19a. Informant's Name/Relationsh Joseph B. Lewi		Brothe						al Route Numb			, State, Zip 20607	*
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To the Hospital or Attending Phys within 24 hours after death. To the Funeral Director: After this completed filled in by the funeral director.	Medical	(Check 2 L Medical Ex	Physician: To the beaminer: On the basis	s of examination	on and/or invest	igation, in n	ny opinior	n, death oc	curred at	the time, date	and place	ce, and	due to the ca	ause(s) and manner stated
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Baltimore, Maryland 21215-0036

Division of Vital Records, P.O. Box 68760

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene, 1 - State Registral Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Day Year **Physician** David Lewis, Jr. 2009 Theodore ecember 21 /Medical ₹acility Name (If not institution, give street and number) 4b. City, Town, or Location of Death County of Death Examiner ENTER If Under 24 Hrs. 8. Date of Birth Month, Day, July 7, 5. Social Security Number 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign 1 ₹ M 2 ☐ F Months Days Hours Min. Washington, DC 1933 76 579-42-8619 Usual Residence of Decedent 10d. Inside City Limits 10a. State 10b. County 10c. City. Town or Location 1 ☐ Yes 2 🖾 No Director Maryland PrinceGeorge's Clinton 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? USA 20735 9320 Fox Run Drive Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1954 1 Pyes 2 □No 1957 If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Bace - American Indian. 11. Marital Status Black, White, etc 1 ☐ Never Married 2 ☐ Married White 1 ☐Yes 2 No Specify. 2 Specify: 3 Nidowed 4 Divorced Completed 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Prince George's College (1-4or 5+) Elementary/Secondary (0-12) County Public Schools Education Specialist 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Sterling Sr. Alice Theodore David Lewis, ပ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Dana Morgan - Daughter 9320 Fox Run Dr., Clinton, Md 20735 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 Burial 2 ☐ Cremation 3 ☐ Removal from State MD Veterans Cemetery 1/4/2010 Cheltenham, MD 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility George P. Kalas Funeral Home, P.A. 21. Signature of Funeral Service ! 6160 Oxon Hill Rd., Oxon Hill, MD 20745 Part / . Enter the disease, or complications that caused the death. Do not enter the mode of dying, shock, or heart failure. List only one / u = on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Due to (or as a consequence Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner 77835TKS Due to (or as a consequence of): Physician/Medical IF FEMALE 23c. If yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant Live birth 2 Fetal death
Pregnant at time of death 3 Ectopic pregnancy in the past 12 months? Month 5 ☐ Other (specify) 1 Tyes 2 TNo 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I 23e. Did tobacco use contribute to the cause of death? þ Completed Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? Yes 2 2 00 1 ☐ Yes 2 🗆 No 1 □ Yes Be 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 2 NR/Outpatient 3 DOA 1 🗌 Inpatient Certification: To 28a. Date of Injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Natural 2 Accident 5 Pending investigation 1 ☐ Yes 2 ☐ No 6 ☐ Could not be 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (SpecIfy) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide

/Medical Examiner The law requires that the death certificate be executed physician and s the burial-trans Division of Vital Records, P.O. Box 68760, attending p for use as 1 signed by t certificate has b irector, page 2 sl To the Hospital or Attending Physician; funeral filled in by 24 hours within 24 hor To the Fune

Funeral

Director

28a-f show

Department of Health and Mental Hygiene. Important: If item 22a or 28a-f sh Important: If item 27 is marked other than "natural", or items 23a or 28a-f sh any injury or other traumatic event, the Madical Evantinating.

Physician

Pages 1 and 2 should be filed within 72 hours after

death with the Maryland

State

31. Date filed (Month **DEC 23** Registrar

Medical

(Check only one)

29b. Signature and title of certifier

H. Wa 345 rembrooke

who completed cause of death (Item 23a)

Print)

12 Sertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

89c. License number

29d. Date signed (Month, Pay, Year)

Suite 103 haldorf Ad 20603

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. amend #5 Per FH C399 1/13/2010 JH amend #5 Per FH C399 1/13/2010 JH of Health and Mental Hygiene 2009 1 - State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month / 2 Physician/ 9:30 PM Thomas Joseph Lavezzo 2009 Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Wicomi co Hospice at The Dalisburg If Under 1 Year If Under 24 Hrs 9. Birthplace (State or Foreign Country) Washington, DC 5. Social Security Number 220–58–536 6. Sex 7. Age (In yrs. last birthday) 8. Date of Birth **Funeral** (Month, Day, Yea 5 / 22 / 195 1 🖾 M 2 🗆 F Hours Director 58 Usual Residence of Decedent permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f sho any injury or other traumatic event, the Medical Examiner must be notified at 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Completed by Funeral Director 1 X Yes 2 No MD Ocean Pines Worcester 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 8 Dinghy Court 21811 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 12. Was Decedent Ever in U.S 14. Race - American Indian, Armed Forces Black, White, etc 1 Never Married 2 Married 1 Yes If Yes, Give 2 🔀 No Baltimore, Maryland 21215-0036 1 Yes 2 No Specify: Specify: 3 Widowed 4 Divorced White Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) Electronic Technician Metro Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ည Joseph Felix Lavezzo Geraldine Rosso 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Juliet Delahanty/Daughter Dinghy Court, Ocean Pines, MD 21811 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 🖾 Burlal 2 🗌 Cremation 3 🔲 Removal from State Gate of Heaven Cemetery 12/24/09 4 Donation 5 Other (Specify) Dagsboro, Delaware Signature of Funeral Service Licensee 22. Name and Address of Facility 4739 Baltimore Avenue RAY Rogers Gasch's Funeral Home, PA Hyattsville, MD 20781 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final CARCINOMA Ph sician/ MALIGNANT disease or condition resulting in death) Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Examine Due to (or as a consequence of): Hospital or Attending Physician: The law requires that the death certificate be executed 24 hours after death. within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completed filled in by the funeral director, page 2 should be detached for use as the burial-trans that initiated events Due to (or as a consequence of): resulting in death) Last Completed by Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE 23c. If yes, outcome of pregnancy

1 Live Birth 2 Fetal death
4 Pregnant at time of death
9 Unknown 23b. Was decedent pregnant 23d. Date of delivery 3 - Ectopic pregnancy in the past 12 months? Month 5 Other (specify) ☐ Yes 2 ☐ No 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 2 No 3 Probably 4 Unknown 1 Yes 24a. Was an 24b. Were autopsy findings available prior to completion of cause of autopsy perform 1 Yes 2 No Be 25. Was case referred to medical 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 XOther (Specify) HOSPICR 2 2 100 유 1 Yes 1 Inpatient 2 ER/Outpatient 3 DOA 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred Natural work? 1 ☐ Yes 2 ☐ No 5 Pending Investigation ☐ Accident 3 ☐ Suicide 4 ☐ Homicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town. State) Medical ertifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check 2 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29b. Signature and title of certifie DO058410 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Hunson Date filed (Month, Day, Year)
DEC 2 3 2009 State Registrar

			For State	State	of Marylan		rtment of H		Mental Hyg	0000	10007
			Registrar			Cer	tificate of L	Death	T -	leg. No 2 0 0 9	17 6 0 0 1
E	Physici	an	1. Decedent's Name (First, Middle,	,					2. Date of Dea	Dav Year	3. Time of Death
	/Medic		Mildred F. Le 4a. Facility Name (If not institution,		ımharl		4h City Town or	Location of Death	December	4c. County of Dea	4:00P M
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	Funeral			6. Sex	7. Age (In yrs.	last birthday)	If Under 1 Year	If Under 24 Hrs.	8. Date of Birth	9. Bi	rthplace (State or Foreign
	Director		130-05-3719	1 □ M 2 🖾 F	92	Yrs.	Months Days	Hours Min.	July 27	, 1917 Ne	ew York
	pu 🔻		Usual Residence of Decedent 10a. State 10b. County		10c Cit	y, Town or Loc	eation				10d. Inside City Limits
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	the N	Director	Maryland Montg	gomery		Bethe	10f. Zip Code			0g, Citizen of What C	ountry?
	3a or	Ö	8027 Fenway	Road			2081	.7	U	nited Stat	es of America
	should be filed within 72 hours after death with the Maryland nd Mental Hyglene. marked other than "natural", or items 23a or 28a-f show imatic event, it as Nexteen Exertine must be rotified at	Funeral	11. Marital Status	12. Was Dec	cedent Ever in U.	S. 13. V	Vas Decedent of H Yes, specify Cuba	ispanic Origin? (S)		14. Race - Am	erican Indian,
9	after or ite		1 ☐ Never Married 2 ☐ Marrie	Armed F ed 1 □Yes If Yes, G	2 X No		Yes 2\ No	Specify:	nican, etc.)	Black, Whi	· ·
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g	al Hyg other	BeC	17. Father's Name (First, Middle, L	ast)					e (First, Middle,	Maiden Surname)	
<u> a</u>	uld be Menta Irked Itic e	2	Joseph Zaretzl	су				Esthe	r Cohen		
ar.	d 2 should be fi th and Mental H 7 Is marked ot traumatic ever		19a. Informant's Name/Relationsh	ip (Type. Print)		19b. Mailin	g Address (Street a	and Number or Ru	ral Route Numbe	r, City or Town, State,	Zip Code)
	es 1 and 2 should b of Health and Ment fitem 27 is markec r other traumatic e		Diane Karlik -	Daughter		8027	enway Ro	ad, Beth			
Š	Pages 1 nent of H int: If ite iry or ot		20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation	3 ☐ Removal from	i State I		ition (Name of atory or other plac		Date	20c. Location - City o	
altimore,	it. Pa rtmer rtant: njury		4 □ Donation 5 □ Other (Sp		Ft		n Cremato		and the second second		l, Maryland
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	/Medical		disease or condition resulting in death)	a	(or as a consequ						
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9	ificate g phys	edical		d							
X Q Q	law requires that the death certifi as been signed by the attending 2 should be detached for use as	hysician/Me	IF FEMALE: 23b. Was decedent pregnant		itcome of pregna		Ectopic pregnancy	v.		23d. Date of de	
O.	e deat	sicia	in the past 12 months? 1 ☐ Yes 2 🗷 No		gnant at time of c		Other (specify)	y		Month	Day Year
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Š,	ires the signe	bγ	Part II. Other significant condition	is contributing to t	leath but not lest	uning in the un	deliyilig cause give	ann raiti.			Probably 4 Unknown
Vital Records,	requ been should	Completed						 	-		
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ē	in: TI tificate or, pa		25. Was case referred to medical	1				26 Diago of Dag	1 ☐ Yes th (Check only or	2/□No	s 2 No
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≝	r Att ter de irecto n by t	rtific	3 ☐ Suicide 6 ☐ Could no 4 ☐ Homicide determin	20e. Plac	e of Injury - At ho ling, etc. (Specif	ome, farm, stre	et, factory, office		28f. Location (S City or Tow	treet and Number or F n, State)	Rural Route Number,
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	To the Hospital or Attending Physician: The law within 24 hours after death. The this certificate has To the Funeral Director: After this certificate has completely filled in by the funeral director, page 2 s	Medical		xaminer: On the						cause(s) and manner a date and place, and du	
	o the	Med	29b. Signature and title of certifier	and ma	iner stated.		29c. License	e number	- 2	29d. Date signed (Mor	nth, Day, Year)
	In		miren 70	izh.			Doo	64871		12-16-0	
	•		30. Name and address of person w	nho completed cau	se of death (Iten	n 23a) (Type, F	Print),				
			Mina Faz	li, MI) 18	OI E.	Jeffers:	ne 5t.	Kocku	rille MD	20852
	Sta		31. Date filed (Month, Day, Year) DEC 17	2000 200	Registrar's Signa	Anna	Ked .			rille MD	
	Registr	đi	DEC T (LUUS KAR	pour p	17					

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 2009 Physician/ Month 406 Cathy Ann LAYTON December Medical 4a. Facility Name (if not institution, give street and number) 4c. County of Death Examiner 4b. City, Town, or Location of Death Washington Hagerstown Washington County Hospital Social Security Number 7. Age (In vrs. last birthday If Under 1 Year If Under 24 Hrs. 8. Date of Birth Date or Day, Year, (Month, Day, Year, 1 1967 9. Birthplace (State or Foreign **Funeral** Country) Mary Land 1 □ M 2 🂢 Months Days Hours Min. **Director** 42 215-90-9555 May Usual Residence of Decedent "natural", or items 23a or 28a-f show edical Examiner must be notified at 10a. State 10b. County 10d. Inside City Limits 10c. City. Town or Location with the Maryland Director 1 Yes 2X No Maryland | Washington Hagerstown 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 21742 USA 13718 Pennsylvania Avenue Apt. within 72 hours after death 12. Was Decedent Ever in U.S. Armed Forces?
1 Yes 2 No Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian. Black, White, etc. þ 1 Never Married 2 X Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 K No Specify. Specify. White Completed 3 Widowed 4 Divorced Medical 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life, DO NOT use retired) permit. Page 1 and 2 should be filed within 73 Department of Health and Mental Hygiene. Important: If item 27 is marked other than any injury or other traumatic event, the Me Elementary/Seconday (0-12) College (1-4 or 5+) 12 Her own home Homemaker 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Kenneth Elsworth Bradley Judy Niblett 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Kenneth Bradley - Father 3874 Hiram Acworth Highway, Dallas, Ga. 30157 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 😾 Burial 2 □ Cremation 3 □ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Green Hills Cemetery 12/27/09 Ashville, N. Carolina 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Minnich Funeral Home 415 E. Wilson Blvd. Hagerstown, Md. 21740 Approximate Interval Between O set and Death 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final Physician Melerip he Medical resulting in death) Due to (or as a consequence of): Examiner Sequentially list conditions, it any, leading to immediate cause. Enter Underlying Examine Due to (or as a consequence or) Hospital or Attending Physician: The law requires that the death certificate be executed Cause (Disease or iinjury that initiated events resulting in death) Last attending physician and for use as the burial-transi Due to (or as a consequence of): Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ____ in the past 12 months? Day Month Year Pregnant at time of death 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I 23e. Did tobacco use contribute to the cause of death? Completed by 1 ☐ Yes 2 ☑ No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of 24a. Was an Jas autopsy page death? certificate I 1 ☐ Yes 2 ☐ No Yes 2 N 25. Was case referred to medical funeral director, Be 26. Place of Death (Check only one) Hospital Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 ☑ No Certificate: To 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA After this 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at 28d. Describe how injury occurred iniury work? 1 ☐ Yes 2 ☐ No 1 Natural 5 Pending safter death.

I Director: Af id in by the fu 2 Accident
3 Suicide Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 28f. Location (Street and Number or Rural Route Number, completed filled in by determined City or Town, State) 24 hours a Funeral D Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. within 2 29b. Signature and title of certifier 29c. License number 41667 MB 12.17.09

State Registrar

13H-0

Medical Compos

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

31. Date filed (Month, Day, Year)

DEC 22 2009

Mclormot

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Month Day 16, 2009 Dec. 5:46p M Lemma @ an Va 4b. City, Town, or Location of Death 4c. County of Death apt.#107 4a. Facility Name (If not institution, give street and number) Montgomerv North Bethesda 10314 Strathmore Hall Street If Under 1 Year If Under 24 Hrs. 9. Birthplace (State or Foreign 5. Social Security Number 6. Sex 7. Age (In vrs. last birthday Days Hours Min. 602-29-5845 1 □ M 2 X F 55 Ethiopia Oct. 7, 1954 Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10a. State 10b. County 1 X Yes 2 □ No M D Montgomery North Bethesda 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number 20852 United States 10314 Strathmore Hill St. apt.#107 12. Was Decedent Ever in U.S. Armed Forces? 1 □ Yes 2 图 No If Yes, Give Year or Dates: 14. Race - American Indian, Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Black, White, etc. 1 Never Married 2 Married Specify: Black 1 ☐ Yes 2 🗷 No Specify. **XX**Widowed 4 ☐ Divorced 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Clerk Sears 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Tekle maria m Tewabech Adal Lemma 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) Teklemariam(brother) 10811 Meadowhill Rd., Silver Spring, MD 20901 Engeda 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition 1 ★ Burial 2 Cremation 3 ★ Removal from State Addis Ababa Cem. 12/19/2009 Addis Ababa 4 □ Donation 5 □ Other (Specify) 21. Signature of Funeral Service Licensee 22. Name and Address of Facility McGuire Funeral Service, Inc. 7400 Georgia Avenue, NW, Washington DC 20012 Luck 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Onset and Death Immediate Cause (Final disease or condition resulting in death) 377 F Due to (or as a consequence of): Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Dause Universe or injury that initiated events resulting in death) Last Due to (or as a consequence of): Due to (or as a consequence of): If yes, outcome pf pregnancy 1□Live birth 2□Fetal de: 23d. Date of delivery 2 ☐ Fetal death 3 ☐Ectopic pregnancy Month 4□Pregnant at time of death 5 Other (specify) 9 Unknown

Physician /Medical Examiner

Important: I any Injury o

Physician

/Medical

Examiner

Director

Funeral

Completed by

Be

ပ

Funeral

Director

show r 28a-f show notified at

'natural", or Items 23a or dical Examiner must be

the Medical

ages 1 and 2 should be filed vent of Health and Mental Hygie t: If Item 27 Is marked other I y or other traumatic event, the

permit. Pages 1 Department of H

filed within 72 hours after death with the Maryland

Maryland 21215-0036

Baltimore,

that the death certificate be executed

Hospital or Attending

death.

after n 24 hou₁. the Funeral Dire

To the P within 2

d in by the

Division or Vital Records, P.O. Box 68760,

burial-tran the page 2

Examine physician Physician/Medical attending pl δ Completed has certificate Be ၉ this Certification:

23b. Was decedent pregnant in the past 12 months? 9 Unknown

23e. Did tobacco use contribute to the cause of death?

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

24a. Was an autopsy performed? Yes 2. No 26. Place of Death (Check only one)

24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☐ No

1 Yes 2 No 3 Probably 4 Unknown

25. Was case referred to medical examiner? 1 Yes 2 No 27. Manner of Death

5 Pending investigation

6 ☐ Could not be determined

18

1 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of Injury (Month, Day Year)

Hospital:

28b Time of 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify)

28c. Injury at Work? 1 ☐ Yes 2 ☐ No 28d. Describe how injury occurred 28f. Location (Street and Number or Rural Route Number, City or Town, State)

Other: 4 Nursing Home 5 Residence 6 Other (Specify)

29a, Certifier

1 Natural

2 Accident

3 ☐ Suicide

4 ☐ Homicide

1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29c. License number

29b. Gignature and title of certifier

31. Date filed (Month, Day, Year)

mo ome

32. Registrar's Signature

29d. Date signed (Month, Day, Year) Paik

30. Name and address of person who completed cause of death (Item 23a) (Type, Print) FR mo

State Registrar

Medical

State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death Reg. No. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Year **Physician** MELTON LEACH aM 00 cempo /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4h City Town or Location of Death Examiner La Plata Medica rarle 5. Social Security Number If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, 9. Birthplace (State or Foreign 7. Age (In yrs. last birthdav) **Funeral** Year) Months Days Hours 1**X** M 2□ F 94 1915 SOUTH CAROLINA Director 248-14-6940 JULY 11. Usual Residence of Decedent 10c. City. Town or Location 10d. Inside City Limits 10a State 10h. County 28a-f show traumatic event, the Madical Examinar must be notified at Director 1 ☐ Yes 2 🕱 No MD CHARLES INDIAN HEAD 10e. Street and Number 10f, Zip Code 10g. Citizen of What Country? ō 5199 SUN DEW COURT 20640 UNITED STATES or items 23a Funeral 11. Marital Status 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. was Decedent Ever in 0.5. Armed Forces? 1 ∰Yes 2 □ No 1942 If Yes, Give Year or Dates: 1943 1 ☐ Never Married 2 ☐ Married Maryland 21215-0036 1 ☐ Yes 2 X No Specify ģ Specify: BLACK 3 XWidowed 4 ☐ Divorced "natural" Completed 15. Decedent's Education (Specify only highest grade completed) Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) 6 LABORER CONSTRUCTION is marked other 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Pages 1 and 2 should be CLARENCE LEACH CARRIE CAMPBELL LEACH 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Department of Health a Important: If item 27 is any injury or other tra once. SHARON LEACH-STEWART/DAUGHTER 5199 SUN DEW COURT, INDIAN HEAD, MARYLAND 20640 Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 1 N Burial 2 ☐ Cremation 3 ☐ Removal from State MARYLAND VEIERANS CEMETERY: 12/30/2009 CHELTENHAM, MARYLAND 4 ☐ Donation 5 ☐ Other (Specify) permit. 22. Name and Address of Facility
THORNICN FUNERAL HOME, P.A.
3439 LIVINGSION ROAD, INDIAN HEAD, MARYLAND 20640 21. Signature of Funeral Service Licensee LYDÍA C. THORNTON JOHNSON MOO583 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Beleteral Physician meumoni disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner porctor Sequentially list conditions Physician/Medical Examiner if any leading to Introduct cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Physician; The law requires that the death certificate be executed burial-trar Due to (or as a consequence of) Division of Vital Records, P.O. Box 68760, the use as IF FEMALE: yes, outcome of pregnancy
Live birth 2 Fetal death
Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy for in the past 12 months?
1 ☐ Yes 2 ☐ No 5 Other (specify) detached 9 Unknown cate has been signed page 2 should be det Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 □ Yes 2 No 3 Probably 4 Unknown Be Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? Yes 2 ☑ No certificate 2 🗆 No 1 ☐ Yes 1 🗆 Yes funeral director, 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 No 1 ☐ Yes 1 Inpatient 2 ER/Outpatient 3 DOA Certification: To this 27. Man, er of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of 28d. Describe how injury occurred After 28c. Injury at Work? or Attending 1 Natural 5 Pending death. investigation 1 ☐ Yes 2 ☐ No 2 Accident hours after death uneral Director: filled in by the Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 ☐ Homicide within 24 hours at To the Funeral C Hospital 29a, Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical completely (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29b. Signature and title of certifie 29d. Date signed (Month, Day, Year) 29c. License number 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 31. Date filed (Month, Day, Year) DEC 23 32/Registrar's Signature State Registrar

DHMH 17 Rev 1/2001

State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death Reg. No. 2 1. Decedent's Name (First, Middle, Last) 2. Date of Death Day **Physician** 12.09 AM Philip December Le Grande 2009 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Harbor Hospital Baltimore Baltimore 5. Social Security Number If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) March 5, 1 7. Age (In vrs. last birthday) 9. Birthplace (State or Foreign **Funeral 1** M 2 □ F Months Days Hours 62 Director 579 62 1589 1947 Washington DC Usual Residence of Decedent death with the Maryland 10c City Town or Location 10a State 10b County 10d. Inside City Limits item 27 is marked other than "natural", or items 23a or 28a-f show other traumatic event, the Medical Examiner must be notified at 1 □Yes 2 □ No Director Maryland Prince George's Forestville 10e. Street and Number 10g. Citizen of What Country? 2000 Overton Drive 20747 United States Completed by Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 tres 2 □ No 19 Hes, Give Year or Dates: 1 O 11. Marital Status Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Bace - American Indian Black, White, etc. 1 Never Married 2 Married 1967 1 ☐ Yes 21☑ No Specify Specify: White 3 ☐ Widowed 4 TX Divorced 1972 16a. Decedent's Usual Occupation 15. Decedent's Education 16b. Kind of Business/Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) College (1-4or 5+) Elementary/Secondary (0-12) Financial Analyst Finance 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Gordon H. LeGrande Margaret S. Hutton ၉ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Pages 1 and 2 s Caroline Gregory (Sister) 10002 Farrar Terr, Cheltenham, MD 20623 if Health item 27 I Saltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State Department of Important: If it any injury or o once. 1 ☐ Burial 2 X Cremation 3 ☐ Removal from State Lee Crematory Dec 18, 2009 Clinton, Maryland 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility Lee Funeral Home, Inc 6633 01d 21. Signature of Funeral Service Licensee Alexndria Ferry Road, Clinton, MD 23a. Part1. Enter the disease, if complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one crase on each line. Approximate Interval Between Onset and Death immediate Cause (Final Hypertenzion **Physician** disease or condition resulting in death) Pulmonary /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner use as the burial-transi and Due to (or as a consequence of): Division or Vital Records, P.O. Box 68760, nding physician The law requires that the death certificate be Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? Month Day Year 5 ☐ Other (specify) 4☐Pregnant at time of death 1 ☐ Yes 2 ☐ No 9□Unknown 9 ☐ Unknown signed by t Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Stricture 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed Aspiration 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an autopsy performed? Yes 2 No 1rrhosis LIVEY 0 1□ Yes To the Hospital or Attending Physician: 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: 1 ☐ Inpatient Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 ☑ No 2 KER/Outpatient 3 DOA မ this 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of Certification: 28d. Describe how injury occurred After Natural 2 ☐ Accident 5 ☐ Pending investigation within 24 hours after useum.

To the Funeral Director; Aft 1 ☐ Yes 2 □ No 6 ☐ Could not be 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide 29a. Certifier 156 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) Medical (Check only one) and manner stated. 29b. Signature and little of certifie 29c. License number 29d. Date signed (Month, Day, Year) December 17 2009

Registrar
DHMH 17 Rev 1/2001

State

7845 Oakwood Road 103.

alen Burne MD2106

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

1a nar

32. Registrar's Signature

101

Amba

31. Date filed (Month, Day, Year)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Day Month DUANE C. MAGISKE 07:33 AM December 28,2009 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Harford Bel Air Upper Chesapeake Medical Center 5. Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year | If Under 24 Hrs. 8. Date of Birth 4/30/1947 9. Birthplace (State or Foreign 208-38-3931 1 X M 2 □ F Months Days Hours Min. Pennsylvania 62 Usual Residence of Decedent 10b. County 10c. City, Town or Location 10d. Inside City Limits 1 ☐ Yes 2 XNo Delta York PA10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code UŚA 17314 440 Quarry Road 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☐ No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status 1 ☐ Never Married 2X Married White 1 ☐ Yes 2 🛛 No Specify: 3 Widowed 4 Divorced 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Education Teacher 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Catherine Sands Mike Magiske 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 440 Ouarry Road, Delta, PA 17314 19a. Informant's Name/Relationship (Type. Print) 440 Quarry Road, Delta, Christina A. Magiske/Wife 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition 1 Burial 2 Cremation 3 Removal from State 1/2/2010 Darlington, MD Darlington Cem. 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Fatheral Service Lice 22. Name and Address of Facility Harkins Funeral Home, Delta, PA 17314 CKobert 23a. Part 1. Enter the disease, of complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Win 37911 2 years Due to (or as a consequence of) Sequentially list conditions, cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Due to (or as a consequence of) 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 23d. Date of delivery 3 Ectopic pregnancy Month Day Year 4 ☐ Pregnant at time of death 5 Other (specify) 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 1 ☐ Yes 2 ☐ No 24a. Was an autopsy performed? 1 ☐ Yes

Physician /Medical **Examiner**

permit. Pages 1 and 2 should be filed within Department of Health and Mental Hygiene. Important: If Item 27 is marked other than any injury or other traumatic event, Inc. M.

Physician

Examiner

Funeral

Director

ir than "natural", or items 23a or 28a-f show the Medical Examinar must be notified at

Marvland 21215-

/Medical

10a. State

Director

Funeral

Completed by

Be

2

attending physician for use as the buris detached Hospital or Attending Physician:

completely filled in by the funeral director, this

Examiner Physician/Medical þ Be Completed Certification: To

9 Unknown

23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No

25. Was case referred to medical examiner?

29b. Signature and title of certifier

Hospital:

5 Pending investigation

6 ☐ Could not be

28a. Date of Injury (Month, Day, Year)

1∐ Yes 2 Mo

27. Manner of Death 1. Natural

2 Accident

3 Suicide

29a. Certifier (Check only one)

4 Homicide

26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 28d. Describe how injury occurred

28c. Injury at Work? 1 ☐ Yes 2 ☐ No

28f. Location (Street and Number or Rural Route Number, City or Town, State)

1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Exeminer: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

> 29c. License number DO0 53568

29d. Date signed (Month, Day, Year)

recapeake 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Ihon DSON MD 82. Registrar's Signature 31. Date filed (Month, Day, Year)

1. Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28b. Time of Injury

State Registrar

12

Medical

s after death

within 24 hours a

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month 2009 **Physician** Dec. 6:55 P M RICHARD MANSON MORRIS JR. /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner Jpper Chesapeake Medical Center Harford Bel 9. Birthplace (State or Foreign Country) Tennessee If Under 1 Year | If Under 24 Hrs. Date of Birth (Month, Day, Year) 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** Days 1**X** M 2□ F Months Hours 84 104-24-1441 Director Usual Residence of Decedent 10d. Inside City Limits 10b. County 10c. City, Town or Location 10a. State show Injury or other traumatic event, the Medical Examiner must be notified at 1 □Yes 2 No Director MD. Harford Street 28a-f 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code ō 21154 4537 United States Madonna Road Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 1 X Yes 2 ☐ No or items 14. Race - American Indian 11. Marital Status Armed Forces?
1 Mayes 2 No
If Yes, Give
Year or Dates: WW II 1 Never Married Married 1 □Yes 2**X** No Specify Specify: \$ 3 Widowed 4 Divorced White Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "natural", any Injury or other traumatic event, Ite Medical Exa Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Give kind of work done during most of working life. DO NOT use retired) LOGISTICS (Specify only highest grade completed) Department Elementary/Secondary (0-12) College (1-4or 5+) Supply Management Specialist 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Richard Morris Thelma Borum Manson ပ္ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 4537 Madonna Road Connie O. Morris (Wife) Street, MD. 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition Dec. Pages 1Å Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) B3e1 Mem. 2009 Bel Air, Maryland Air Gardens: 22. Name and Address of Facility Kurtz & Son Funeral E.G. Jarrettsville, Maryland Home, P.A. Approximate Interval Between Onset and Death 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final **Physician** Myocardia disease or condition resulting in death) /Medical Due to or as a consequence of Examiner bronaly Sequentially list conditions, if any, leading to infine date cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last burial-trai requires that the death certificate be execu Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, physician Physician/Medical the attending p IF FEMALE: If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? Month Day Vear 5 Other (specify) cate has been signed by the page 2 should be detached 1 ☐ Yes 2 ☐ No 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 2 3 Probably 4 ☐ Unknown 1 ☐ Yes 2 ☐ No Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an certificate has 2 □No 1 □ Yes 2 💽 1 ☐ Yes funeral director, 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 ☐ Inpatient 2 ☐ R/Outpatient 3 ☐ DOA Medical Certification: To this 28a. Date of Injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred the Hospital or Attending 1 Natural 5 Pending 1 ☐ Yes 2 ☐ No investigation 2 Accident hours after death uneral Director; 6 Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by determined 4 Homicide within 24 hours a 29a. Certifier 🔀 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. completely 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one)

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Richard Manson monis

State Registrar

29b. Signature and title of certifier

31. Date filed (Month, Day, Year)

Ba

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

DHMH 17 Rev 1/2001

29c. License number

D. 500 Upper Ohe Sapeake Dr. Bel Air, MO
32. Registrar's Signiture

00066641

29d. Date signed (Month, Day, Year)

			For State		State of	f Marylar	nd / Depa				and N	1ental Hy	giene		
			Registrar	- (First Adida)	4)		Cer	tificate	of D	eath			Reg. No.	<u> 2009</u>	42674
	Physici Medi		1. Decedent's Name	e (First, Middle, L	CATHEI	RINE	LOUISE	MI	LLER			2. Date of De Month Decemb	Dav	3 2009	3. Time of Death
,	Exami	ner	4a. Facility Name (if	_		,		4b. City, T	ſown, or	Location o	of Death		4c.	County of Dea	th
-	<u> </u>	H			rial Hosp				eder				I	rederi	ck
	Funeral Director		5. Social Security No. 219–44–44	446	Sex 1 D M 2 X F	7. Age (In yrs. 6.		If Under Months	1 Year Days	If Under Hours	24 Hrs. Min.	8. Date of Bir 5 17 -	th 199446		thplace (State or Foreign untry) MD
	land show dat	2	Usual Residence of 10a. State	Decedent 10b. County		10c. Gi	ty, Town or Loc	ation							404 1-14-07-11-7-
	laryla ga-f s ified	Director	MD	Frede	rick		ederic								10d. Inside City Limits 1 Yes 2 No
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	leath items er m	Funeral	11. Marital Status	o criazo.	12. Was Deced			Vas Decede	ent of His	panic Orig	gin? (Spe	cify Yes or No-	1	4. Race - Ame	rican Indian.
036	1 and 2 should be filed within 72 hours after death with the Maryland of Health and Mental Hygiene. Item 27 is marked other than "natural", or items 23a or 28a-f shoother traumatic event, the Medical Examiner must be notified at	ğ	1 Never Marri		Armed Ford 1 Yes If Yes, Give Year or Dat	2 🗓 No		Yes, specif			, Puerto l	Rican, etc.)		Black, White	
2-0	hour hatu dical	Set	/S.00	15. Decedent's	Education		16a. Deced	ent's Usual	Occupa	tion			16b. Kin	nd of Business	
2	nin 72 ne. han "	Completed	Elementary/Seco		grade completed) College (1-4	or 5+)	life. DC	ind of work NOT use r	retired)	ıring most	of workir	ng			·
121	d with lygier ther t	Be C	12] Di	letici	Lan				Assi	sted L	iving
Maryland 21215-0036	should be filed within 7: n and Mental Hygiene. 7 is marked other than raumatic event, the Me	To B	17. Father's Name (F Meynary									(First, Middle, rances			
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Σ	and 2 sl Health a tem 27 is	İ	Mary Lip	part	Daug	hter						derick			Code)
ore			20a. Method of Disp			20b. F	Place of Dispos	ition (Name	of			ate		cation - City or	Town, State
Ĕ	Page 1 ment of 1 ant: If its ury or of			5 Other (Spe	☐ Removal from S cify)		nt Oliv				-4-2	010	Fred	lerick,	Maryland
Baltimore,	permit. Page Department of Important: If any injury or once,		21. Signature of Fun	eral Seral Lic	han) MO11	76 10	Name and	Address	of Facility	Keen Str	ey & Ba	asfor	d P.A.	F.H.
			23a. Part . Enter th	ne disease, or contract	nplications that ca one cause on each	used the deat									Approximate
-	Physician/		Immediate Cause (F disease or condition	Final	- a Oneuc									i	Interval Between Onset and Death
ليد	Medical Examiner		resulting in death)	•		as a consequ	ence of):								1 Week
		er	Sequentially list con	nditions,		stene									75 years.
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õ	endin r use	an/l	IF FEMALE: 23b. Was decedent p	pregnant	23c. If yes, outco	me of pregna		Ectopic pre	ananou				23	3d. Date of deli	very
. Box 68760	e deatl the att	Physician/M	in the past 12 m 1 ☐ Yes 2 🔀 9 ☐ Unknown	(No		nt at time of c		Other (spec				· · · · · · · · · · · · · · · · · · ·		Month	Day Year
P.0	hat thed by	by Ph	Part II. Other signific	cant conditions	contributing to dea	th but not resi	ulting in the un	derlying cau	use give	n in Part I.		23e. Did to	bacco use	e contribute to	the cause of death?
Ś.	uires 1 n sign ald be	q p	Dabeles	mellit	us II,	4TW (hype-1	Kr Sien).						obably 4 🗆 Unknown
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<u>a</u>	ian: T rtifica ctor, p	Bec	25. Was case referred examiner?	d to medical				_	26. Plac	e of Death	(Check o	1 \(\text{Yes} \)	2 No	1 L Yes	2 No
₹ ;	hysic his ce I direc	욘	1 🗆 Yes 2 🔀	No	Hospital:	patient 2 🗆	ER/Outpatient		Oak				ence 6	Other (Specif	iv)
ָס ר	Ing P		27. Manner of Death 1 Natural	5 Pending	28a. Date of (Month,	injury <i>Day, Year)</i>	28b. Time of injury	28c	. Injury a work?			d. Describe h	_		
Sior	death death stor: / the f	Certificate:	2 ☐ Accident 3 ☐ Suicide	Investigation	ne			М		s 2 🗆 N	10				
Division of Vital Records, P.O.	tal or A s after al Direct ed in by		4 U Homicide	determined	building	etc. (Specify)	me, farm, stree	t, factory, o	ffice		28	3f. Location (Sa City or Town		Number or Rura	d Route Number,
- :	Io the hospital or Attendum Physician: The law requires that the death certific within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending to completed filled in by the funeral director, page 2 should be detached for use as	Medical	(UTIOCK Z L	⊒ wedicai Exam	vsician: To the besi niner: On the basis se Practioner: To	of examination	and/or investig	ation in my	opinion	death occ	urrad at th	a time date ar	d place ar	nd due to the er	una(a) and manner stated
i	Nithi To th		29b. Signature and tit	le of certifier		22. 21. 119			icense n		na piace,			signed (Month,	
			Kive	ishaen	ND			1200	062	975				129120	
	5		30. Name and addres	s of person who	completed cause of			nt)			2			-1160	
ı,	Stat	e 6	31. Date filed (Month,	Day, Year)		5 Strar's Signatu		CETIC	KA	AD	417	01			
	Registra	_	JANO	7 2010	anna	1. 6	lass								

21502

		,	For State Registrar	State of Ma		partment of ertificate of	Health and M <i>Death</i>	Re	eg. No 2 9	42675
	Physici /Medio	al	1. Decedent's Name (First, Middle, Last NEVA JOSEPHINI The Society Name (Management of the Control of the Con	E MacMANN	IS	Ale City Toyen	ar Location of Dooth	2. Date of Deat Month 12	Day Year 30 2009 4c. County of Dear	3. Time of Death 1:35 A.M
)	Examin Funeral	er	4a. Facility Name (If not institution, given WESTERN MD REGIO) 5. Social Security Number 6. S	NAL MEDICA	L CENTER	CUMBER	If Under 24 Hrs.	8. Date of Birth (Month, Day,	ALLEGA	NY thplace (State or Foreign
6	Director		Usual Residence of Decedent	□M 2 X F	95 Yrs.	Months Days	Hours Min.	09/19/	1914 M	ARYLAND
:	/2 hours arrer death with the Maryland natural", or items 23a or 28a-f show Jeal Examinar must be notified at	Director	MD ALLEG.	ANY	10c. City, Town or L	LAND			0g. Citizen of What Co	1 ☐ Yes 2 No
	NIII NIII		10e. Street and Number			10f. Zip Code		'		ountry :
	s 23a	eral	10301 CHRISTIE R		Turnin It O. I do	215		sif . Va a or No	U.S.A.	viann Indian
2-003e	ours after death v ral", or items 238 Examine must	by Funeral	11. Marital Status 1 □ Never Married 2 □ Married 3 ☒ Widowed 4 □ Divorced	12. Was Decedent I Armed Forces? 1 Tyes 2 N If Yes, Give Year or Dates:	lo	. Was Decedent of If Yes, specify Cul 1 ☐ Yes 2 💆 No	Hispanic Origin? (Spectan, Mexican, Puerto In Specify:	Rican, etc.)	14. Race - Ame Black, White Specify: WI	
ặ .	"natural";	ed	15. Decedent's Ed		16a. Dec	edent's Usual Occu	pation		16b. Kind of Business	
	within jiene. r than "	Completed	(Specify only highest grades and Specify only highest grades Specifically (0-12)	de completed) College (1-4or 5	+) life.	DO NOT use retire	during most of workingd) SECRETARY	ng	RETAIL	
<u>D</u>	be riled ntal Hygi od other event, the	Be C	17. Father's Name (First, Middle, Last)				18. Mother's Name	(First, Middle, N	Maiden Surname)	
<u>a</u>	و مراج ب	To B	JOSEPH H. WILSON				NEVA PE	ARL REI	GER	
ary	s I and 2 should f Health and Mei fem 27 Is marke other traumatic	-	19a. Informant's Name/Relationship (Type. Print)					r, City or Town, State, .	Zip Code)
= '	and 2 ealth a n 27 la		CHARLENE TYSON /	GRANDDAUG	HTER 14	18 DOLPHI	N LANE, HO	LBROOK,	NY 11741	
9 .	ਰ = 2 de		20a. Method of Disposition 1 □ Burial 2 🛣 Cremation 3 □ 4 □ Donation 5 □ Other (Specif			position (Name of ematory or other place) LI CREMAT			20c. Location - City or CRESAPT	
Daltim	permit. Par Departmen Important: any Injury once.		21. Signature of Funeral Service Vicer		uch	22. Name and Addr HAFER F 1302 NA	ess of Facility UNERAL SEF TIONAL HIO	RVICE, P	A. AVALE, MD	21502
,	hysician /Medical xaminer		23a. Part1. Enter the dise see, or com shock, or heart failure. List only Immediate Cause (Final disease or condition resulting in death)	olications that caused one cause on such in a.			ring, such as cardiac c		est,	Approximate Interval Between Onset and Death
b	oale be executed by sician and the burial-transit	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	c	a consequence of):					
2	hysic the bi	lical		d						
O. BOX 0	Arenalists and are the law requires that the death certain or death. ector: After this certificate has been signed by the attending play the funeral director, page 2 should be detached for use as t	Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 ☑ No 9 □ Unknown	23c. If yes, outcome 1 Live birth 4 Pregnant at 9 Unknown	2 Fetal death 3	□ Ectopic pregnar □ Other (specify)	ncy		23d. Date of de Month	livery Day Ye ar
as, r.	signed by	Š	Part II. Other significant conditions of	ontributing to death bu	ut not resulting in the	underlying cause g	iven in Part I.		bacco use contribute to	o the cause of death?
II Records,	ding rifstrain. The law req h. After this certificate has beer funeral director, page 2 shou	Completed						24a. Was a autops perforr	med? prior to death?	utopsy findings available completion of cause of
ig i	ertific ctor,	Be (25. Was case referred to medical examiner?				26. Place of Death	(Check only on	ne)	
0	his c	0	1 ☐ Yes 2 ☑ No	Hospital: 1 ☐ Inpatie	nt 2 ER/Outpati	ent 3 DOA		me 5 Reside	ence 6 ☐ Other (Spe	ecify)
	eath. or: After the funera	ertification: T	27. Manner of Death 1 Natural 5 Pending 2 Accident investigation		ry 28b. Time y, Year) Injury	Wa	ury at 2 ork? □Yes 2 □ No	28d. Describe ho	ow injury occurred	
DIVIS	of the hospital of Attending within 24 hours after death. To the Funeral Director: After completely filled in by the fun	Certific	3 ☐ Suicide 6 ☐ Could not be determined	28e. Place of Injubulding, etc	ury - At home, farm, s c. (Specify)	street, factory, office		28f. Location (St City or Town	treet and Number or R n, State)	ural Route Number,
1	in 24 hour	Medical (f examination and/or				cause(s) and manner a late and place, and du	
Ş	With To th	Σ	29b. Signature and title of certifier	7/1	/		nse number 54005	2	29d. Date signed (Mon 12/30/2	

31. Date filed (Month, Day, Year) State Registrar

- 1221-E NATIONAL HIGHWAY, LAVALE, MD SHIV KHANNA, M.D. 32. Registrar's Signature

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

1- State Certificate of Death	
	Reg. No. 3. Time of Death
Physician Iohn William Myong In	cember 26 2009 0100 A M
/Medical SOITH WITITAIN TYPETS, ST. Dec. Examiner 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death	4c. County of Death
147 Hollywood Beach Road Chesapeake City	Cecil
Funeral 5. Social Security Number 6. Sex 7. Age (In yrs, last birthday) If Under 1 Year If Under 24 Hrs. 8. Days Hours Min. (In yrs, last birthday) Months Days Hours Min. (In yrs, last birthday) If Under 1 Year If Under 24 Hrs. 8. Days Hours Min. (In yrs, last birthday) If Under 1 Year If Under 24 Hrs. 18. Days Hours Min. (In yrs, last birthday) If Under 1 Year If Under 24 Hrs. 18. Days Hours Min. (In yrs, last birthday) If Under 1 Year If Under 24 Hrs. 18. Days Hours Min. (In yrs, last birthday) If Under 1 Year If Under 24 Hrs. 18. Days Hours Min. (In yrs, last birthday) If Under 1 Year If Under 24 Hrs. 18. Days Hours Min. (In yrs, last birthday) If Under 1 Year If Under 24 Hrs. 18. Days Hours Min. (In yrs, last birthday) If Under 1 Year If Under 24 Hrs. 18. Days Hours Min. (In yrs, last birthday) If Under 1 Year If Under 24 Hrs. 18. Days Hours Min. (In yrs, last birthday) If Under 1 Year If Under 24 Hrs. 18. Days Hours Min. (In yrs, last birthday) If Under 1 Year If Under 24 Hrs. 18. Days Hours Min. (In yrs, last birthday) If Under 1 Year If Under 24 Hrs. 18. Days Hours Min. (In yrs, last birthday) If Under 1 Year If Under 24 Hrs. 18. Days Hours Min. (In yrs, last birthday) If Under 1 Year If Under 24 Hrs. 18. Days Hours Min. (In yrs, last birthday) If Under 24 Hrs. 18. Days Hours Min. (In yrs, last birthday) If Under 24 Hrs. 18. Days Hours Min. (In yrs, last birthday) If Under 1 Year If Under 24 Hrs. 18. Days Hours Min. (In yrs, last birthday) If Under 1 Year If Under 24 Hrs. 18. Days Hours Min. (In yrs, last birthday) If Under 1 Year If Under 24 Hrs. 18. Days Hours Min. (In yrs, last birthday) If Under 1 Year If Under 24 Hrs. 18. Days Hours Min. (In yrs, last birthday) If Under 1 Year If Under 24 Hrs. 18. Days Hours Min. (In yrs, last birthday) If Under 1 Year If Under 24 Hrs. 18. Days Hours Min. (In yrs, last birthday) If Under 24 Hrs. 18. Days Hours Min. (In yrs, last birthday) If Under 24 Hrs. 18. Days Hours Min. (In yrs, last birthday) If Under 24 Hrs. 18. Days Hours Min. (In yrs, last birthday) If Unde	te of Birth onth, Day, Year) 9. Birthplace (State or Foreign Country)
Director 221–34–9255 59 Tis. FEI	18, 1950 Delaware
Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location	10d. Inside City Limits
Maryland Cecil Chesapeake City	1 ∐Yes 2 🔯 No
Maryland Cecil Chesapeake City 10e. Street and Number 10f. Zip Code	10g. Citizen of What Country?
हिंदी हिंदी 147 Hollywood Beach Road 21915	United States
147 Hollywood Beach Road 21915 11. Marital Status 2 Married Process? 2 Married Process? 2 Married Process? 2 Married Process? 3 Was Decedent of Hispanic Origin? (Specify Young) If Yes, specify Cuban, Mexican, Puerto Rican, Pu	s or No- 14. Race - American Indian,
1 Never Married 2 Married	
S 3 Widowed 4 Divorced If Yes, Give Year or Dates: 1 Yes 2 M No Specify:	Specify: White
The state of the s	16b. Kind of Business/Industry
College (1-4or 5+) Selementary/Secondary (0-12) 12 College (1-4or 5+) Owner/Operator	Trucking
The state of the s	Middle, Maiden Surname)
Te ခြေမျိုင်း ပြု John W. Myers, Sr. Helen Mili	er
19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route)	e Number, City or Town, State, Zip Code)
Vicki L. Myers/Wife 147 Hollywood Beach Road,	Chesapeake City, MD 21915
20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c Method of Disposition (Name of cemetery, crematory or other place) Date December	20c. Location - City or Town, State
E 如	West Chester, PA
Second Hesideric of December 10a. State 10b. County 10a. State 10b. County 10a. State 10b. County 10a. State 10b. County 10b. County 10b. County 10b. County 10b. County 10b. County 10b. City, Town or Location 10c. City in Location 10c. City	s. P.A.
103 W. Stockton Street	, Elkton, MD 21921
23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or resp shock, or heart failure. List only one cause on each line. Immediate Cause (Final	ratory arrest, Approximate Interval Between Onset and Death
disease or condition disease or condition a. L. ung ancer	
Due to (or as Consequence of):	
Sequentially list conditions, if any, leading to immediate cause (Disease or injury) Cause (Disease or injury)	
Due to (or as a consequence of): Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): C. Due to (or as a consequence of):	The state of the s
Og 28 og	
the principle of the pr	
9 5 6 8 9	
X O G G G G G G G G G G G G G G G G G G	23d. Date of delivery Month Day Year
YOU SEE THE PROPERTY OF SE	
Your conditions of the part of	e. Did tobacco use contribute to the cause of death?
Subclavian Vein Thombosis	1 Yes 2 No 3 Probably 4 Unknown
The law reduires a spen signe est to the same of the law to	a. Was an 24b. Were autopsy findings available
The Land	autopsy prior to completion of cause of death? ☐ Yes 2 No 1 ☐ Yes 2 ☐ No
25. Was case referred to medical examiner?	
Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA Other: 4 Nursing Home 5	☐ Residence 6 ☐ Other (Specify)
28a. Date of Injury 28b. Time of Injury 28c. Injury at Work?	scribe how injury occurred
2 Accident investigation M 1 Yes 2 No	
Solution	ation (Street and Number or Rural Route Number, or Town, State)
29a. Certifier 20a. Certifier 20a. Certifier 20a. C	e to the cause(s) and manner as stated.
1 1 1 1 1 1 1 1 1 1	e time, date and place, and due to the cause(s)
	29d. Date signed (Month, Day, Year)
Doors675	12/28/09
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Robert A. Monteleone Mi) III LU. High St. St.	Suite 214, E/Kton Miggz1
State 31. Date filed (Month, Day, Year) 32. Registrar's Signature	27921

State Registrar

DHMH 17 Rev 1/2001

			for State Registrar	State of M	Maryland		artment of H		and Me		giene Reg. No.	2009	9 42	677
	Physici	an	1. Decedent's Name (First, Middle,	,						2. Date of De Month	Day	Year	3. Time o	
	/Medic	cal	4a English Name (If not institution	Josephine		ell	4h City Tayan	. I a satism s		Decemb	er 2	6 2009		РМ
	Examir	ier	4a. Facility Name (If not institution, Caraway Manor	give sireet and numbe	()		4b. City, Town, or Elkton		Death		4c.	County of Dear	ırı	
	Funeral			6. Sex 7. A	Age (In yrs. last		If Under 1 Year Months Days	If Under Hours	24 Hrs. 8	B. Date of Bir (Month, Da	th v. Year)	9. Bir	thplace (State	or Foreign
	Director		203-05-8465 Usual Residence of Decedent	1	88	Yrs.	- Bayo	Tiodis		May 7,			ngland	
	yland		10a. State 10b. County		10c. City, T	own or Lo	cation						10d. Inside C	City Limits
	e Mar la-fsh	ctor	Maryland Ceci	1	E1	kton							1 □ Yes	2 X No
	vith the	Director	10e. Street and Number				10f. Zip Code					zen of What Co		
	eath v	Funeral	269 Maloney Roa	12, Was Deceden	t Ever in IIS	13 1	21921		igin? (Speci	ify Voe or No		Jnited 14. Race - Ame		
٥	after d or item		1 ☐ Never Married 2 ☐ Marrie	Armed Forces d 1 ☐ Yes 2 [7]	?] No		Was Decedent of H			can, etc.)		Black, White		
1215-0036	filed within 72 hours after death with the Maryland Hygiene. Hydiene. than "natural", or items 23a or 28a-f show ent, the Medical Examination at the million at	d by	3 X Widowed 4 ☐ Divorced	If Yes, Give Year or Dates	:		I∐Yes 2 X INo	Specify:				Specify: Wh	ite	
2	n 72 h "natu	Completed	15. Decedent's (Specify only highest	Education grade completed)	1	(Give	dent's Usual Occup kind of work done of OO NOT use retired	durina most	t of working		16b. Kir	nd of Business/	Industry	
717	d withi giene. rr thar	omb	Elementary/Secondary (0-12)	College (1-4or	5+)		cretary	,			(Chemica	1	
yland	be filed tal Hy d othe event,	Be C	17. Father's Name (First, Middle, La	ast)				18. Mothe	er's Name (First, Middle,	Maiden S	Surname)		
<u>Ş</u>	d Men d Men narke natic	은	George E. Burgh							E. Wil				
<u>z</u>	nd 2 sh ulth an 27 is r r traur		19a. Informant's Name/Relationshi Darrell A. Mitc				ng Address <i>(Street a</i> dwards La					10wn, State, 2 21901	Zip Code)	
Ģ,	of Hea	- (6	20a. Method of Disposition	-	20b. Plac	e of Dispo	sition (Name of patory or other plac	e) D	ecemb			cation - City or	Town, State	
Ē	. Page ment tant: If		1 X Burial 2 ☐ Cremation 3 4 ☐ Donation 5 ☐ Other (Spe		• Cher Meth	odis	t Cemeter	$\mathbf{v} = 13$	80. 20	09	C	herry l	Hill, M	ID
baltimor	permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Introduction 1 them 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examination and by notified at once.		21. Signature of Funeral Service Li	S. Hud	Gs	Hi	Name and Address CKS Home 3 W. Sto	for	Funer Stre	als, P et. El	. A .	- 20 - 43	21921	
		32 11	23a. Part1. Enter the disease, or c shock, or heart failure. List or Immediate Cause (Final	nly one cause on each	line	Do not ent	er the mode of dyin	g, such as	cardiac or				Approximat Interval Bet Onset and	Death
	hysician /Medical		disease or condition resulting in death)	a	s a consequen	ce of):	f Failure Hearf D	2					unhna	WY
E	Examiner		Sequentially list conditions.	b. Alhen			Hearf D	1500c	se				Unknow	wn
· ·	red nsit	nine	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	Due to (or a	s a consequen	ce of):								
,	icate be executed physician and the burial-transit	Examiner	that initiated events resulting in death) Last	c Due to (or a	s a consequen	ce of):								
00/0	are be hysicik he bur	dical		d										
ŏ :	ding p	Med	IF FEMALE:	00- 16										
5	the death certific the attending posterior is ched for use as	Physician/Me	23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown		2 Fetal de at time of deat	ath 3 □] Ectopic pregnancy] Other <i>(sp</i> ec <i>ify)</i>	/			2	3d. Date of de Month		Year
֡֜֞֜֜֜֜֝֜֜֜֜֜֜֜֜֜֜֜֜֜֜֜֜֜֜֜֜֜֜֜֜֜֜֜֜֜֜֜	s been signed by the should be detached	by Ph	Part II. Other significant condition	s contributing to death	but not resultin	g in the ur	iderlying cause give	en in Part I.		23e. Did to	obacco us	se contribute to	the cause of	death?
S C	equire sen siç ould b									1 🗆 1	′es 2□]No 3∏Pi	robably 4 😡	Unknown
ם ומ	in the hospital of waterung ruystrain. The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit.	Completed								24a. Was autop perfo 1 □ Yes		24b. Were au prior to death? 1 □ Yes	utopsy findings completion of c 2 □ No	available cause of
7	s certif	o Be	25. Was case referred to medical examiner? 1 ☐ Yes 2 ☐ No	Hospital:	0.CI.ED	(O. A)	Othe			Check only o		¥.	Assis	ted
5	After this funeral di	\vdash	27. Manner of Death	28a. Date of Inj		b. Time of Injury	28c. Injury Work	/ at		d. Describe h		Other (Spe	<i>cify</i> Livin	g
2	eath. or: Af	catio	1 ✓ Natural 5 ☐ Pending 2 ☐ Accident investiga	tion	ay, 16a/)	injury		.r Yes 2 □1	No					
	rs after drain Direct	Certification:	3 ☐ Suicide 6 ☐ Could no 4 ☐ Homicide determin	ed 28e. Place of Inbuilding, e	etc. (Specify)		eet, factory, office			City or Tov	rn, State)	l Number or Ru		nber,
1000	within 24 hours after death. To the Funeral Director: A completely filled in by the fu	edical	29a. Certifier (Check only one)	Physician: To the bes caminer: On the basis and manner s	of examination	dge, death and/or inv	occurred at the tin restigation, in my of	ne, date an pinion, dea	nd place, an th occurred	d due to the at the time,	cause(s) date and	and manner as place, and due	s stated. to the cause(s	s)
,	Vitr Con	Σ	29b. Signature and title of certifier	lder smi)		29c. License	2332	2		29d. Date	signed (Mont.) 2 / 29 / 2		
	5		30. Name and address of person with the second seco	no completed cause of $V \mathcal{M} \mathcal{D}$	death (Item 23	a) (Type, I	Doo Print) High	St,	Elh	Ton M	02	1924		
	Stat		31. Date filed (Month, Day, Year)		trar's Signature		0	*						
MHC	Registra		JAN 0 7 2010	Beneva &	- par	Plane!		-						

Division of Vital Records, P.O. Box 68760, To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

ian	for State of M		ertificate of Death		Reg. No. 2009 426						
	1. Decedent's Name (First, Middle, Last)			2. Date of De Month	Day Year						
cal		Menasion	45 Cit Town and and in	Decemb		A M					
ner	4a. Facility Name (If not institution, give street and number,)	4b. City, Town, or Location	of Death	4c. County of Death						
	Union Hospital 5. Social Security Number 6. Sex 7. Ac	ge (In yrs. last birthday	E1kton	r 24 Hrs. 8. Date of Bir	th 9. Birthplace (State or F	Foreign					
	1 DM 207 E	74 Yrs.	Months Days Hours Min (Month Day Year) Country)								
٦٢	10a. State 10b. County	10c. City, Town or L			10d. Inside City 1 ☑ Yes 2						
Funeral Director	Pennsylvania Chester	0xford									
ä	10e. Street and Number		10f. Zip Code		10g. Citizen of What Country?						
Fa	21 Myrtle Street		19363		United States						
nu	11. Marital Status 12. Was Decedent Armed Forces	Ever in U.S. 13	. Was Decedent of Hispanic O If Yes, specify Cuban, Mexica	rigin? (Specify Yes or No an, Puerto Rican, etc.)	 14. Race - American Indian, Black, White, etc. 						
d by F	1 ☐ Never Married 2 ☐ Married 1 ☐ Yes 2 🛣 If Yes, Give Year or Dates:	No	1 □Yes 2 X No Specify	π.	Specify: White						
Completed by	15. Decedent's Education (Specify only highest grade completed)	(Giv	edent's Usual Occupation re kind of work done during mo . DO NOT use retired)	16b. Kind of Business/Industry							
mo	Elementary/Secondary (0-12) College (1-4or 1)	5+)	omemaker		In Her Own Home						
Be C	17. Father's Name (First, Middle, Last)			ner's Name (First, Middle	First, Middle, Maiden Surname)						
To B	John Hansen		E1	izabeth Will	kins						
H	19a. Informant's Name/Relationship (Type. Print)	19b. Mai			ner, City or Town, State, Zip Code)						
	Christine Stevens/Daughten		9 South Creek								
	20a. Method of Disposition 1 □ Burial 2 □ Cremation 3 □ Removal from State		position (Name of	December	20c. Location - City or Town, State						
	4 □ Donation 5 □ Other (Specify) 21. Signature of Funeral Service Licensee	Springfield, PA									
	Hicks Home for Funerals, P.A. 103 W. Stockton Street, Elkton, MD 21921 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest. Approximate										
	shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) a. Due to (or as a consequence of): Due to (or as a consequence of):										
sal Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last b. Due to (or as a consequence of): c. Due to (or as a consequence of):										
/Medical	IF FEMALE: 23c. If yes, outcome	e of pregnancy	_		COAL Date of delivery						
ciar	23b. Was decedent pregnant in the past 12 months? 1 ☐ Ves 2 ☑ No 9 ☐ Unknown		23d. Date of delivery Month Day Year								
hysi	Part II. Other significant conditions contributing to death b	obacco use contribute to the cause of death? Yes 2 No 3 Probably 4 Unknown									
ed by Physi				12	Yes 2 No 3 Probably 4 Uni	knowr					
Completed by Physi				24a. Was auto perfo	an 24b. Were autopsy findings av	ailable					
a)	25. Was case referred to medical		26. Plac	24a. Was	an 24b. Were autopsy findings average prior to completion of caudeath? 2 🗖 No 1 🖂 Yes 2 🗐 No	ailable					
Be	examiner?	ent 2 □ ER/Outpatie	Othor	24a. Was auto perfo 1 ∐ Yes	an psy prior to completion of cau death? 2 ☑ No 1 ☐ Yes 2 ☐ No one)	ailable					
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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. amend item 8 per fb g900 to Health and Mental Hygiene Certificate of Death Reg. No. 2

9. Birthplace (State or Foreign

10d Inside City Limits

1 □Yes 2√□No

Virginia

White

Specify:

Month

1 ☐ Yes

29d. Date signed (Month, Day, Year)

Solomons, MD 20688

Day

24b. Were autopsy findings available prior to completion of cause of death?

2**X** No

Year

1. Decedent's Name (First, Middle, Last) 2. Date of Death **Physician** 12/19/2009 <u>Isabelle C. Miller</u> /Medical 4a. Facility Name (If not institution, give street and number)

The Hermitage 4b. City. Town, or Location of Death 4c. County of Death Examiner Calvert St. Johns Creek Solomons Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birt 909 (Month, Day, Year) **Funeral** (Month, Day, Year) 9/17/2009 1 □ M 2 🛛 F Months Days Hours Min 578-09-5063 Director 100 Usual Residence of Decedent permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any Injury or other traumatic event, If a "exited Examination in items any once. 10a. State 10b. County 10c. City, Town or Location Director MD Calvert Solomons 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? United States 13325 Dowell Road 20688 Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 No Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 11 Marital Status 1 ☐ Yes 2X☐ If Yes, Give Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No þ Specify: 3X Widowed 4 □ Divorced Completed Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Government 12 Secretary 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Donnie Catherine Reid ၀ William Joseph Compher 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) <u>Gail S. Lucas</u> Daughter 12450 White Oak Ct. Dunkirk, MD 20754 20a. Method of Disposition Place of Disposition (Name of 20c. Location - City or Town, State Energy crematory of other place) X Burial 2 Cremation 3 Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 12/26/2009 Lovettsville, VA Union Cemetery 21. Sign tv e of Funeral Service Lice 22. Name and Address of Facility Loudoun Funeral Chapels 158 Catoctin Cr. SE Leesburg, VA 20175 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or hear dailure. List only on cause on each line. Immediate Cause (Final disease or condition resulting in death) Concestive Hear **Physician** /Medical Due to as a consequence of): Examiner Cardia 3 chemic Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to (or as a consequence on To the Hospital or Attending Physician: The law requires that the death certificate be executed as the burial-tran Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760 Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months? 3 Ectopic pregnancy signed by the a 5 ☐ Other (specify) ☐Yes 2 No 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Be Completed by 20 No 3 Probably 4 Unknown 1 Tes certificate has briector, page 2 s 24a. Was an autopsy 1 ☐Yes 2 ☐No 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) r this c Hospital: 1 Yes 2X No 1 X Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Medical Certification: To 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of Injury 28c. Injury at Work? 28d. Describe how injury occurred 5 ☐Pending investigation 1 X Natural 1 ☐ Yes 2 ☐ No within 24 hours after death

To the Funeral Director: completely filled in by the f 2 Accident 3 ☐ Suicide 6 ☐ Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 ☐ Homicide textifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) (Check only one)

and manner stated.

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Tardio M.D

State Registrar 29b. Signature and title of certifier

DHMH 17 Rev 1/2001

14090 Solomons Island Rd. South

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Manyland / Department of Health and Mental Hydiene

			For State Registrar		State of M	aryland	•	rtment of F tificate of D		na ivie	-	giene Reg. No	0000	1 1 2 5 0 0	
			Decedent's Name	(First, Middle, Last	t)		00/1	modito or E	- Cutin		2. Date of De	ath	to a later of	3. Time of Death	
	Physicia Medic					MADEI	INE	MARTIN			Month Decem	ber	15 200	9 2:12 AM	
	Examin	er		· -	institution, give street and number)			4b. City, Town, or Location of Death				4c. County of Death			
	Funeral		F'rederic 5. Social Security Nu	mber 6. Se	al Hospit		st birthday)	Freder If Under 1 Year	If Under 24		8. Date of Bir	th	Frederi	irthplace (State or Foreign	
	Director		219 28 59	01	☐ M 2 X F	77	Yrs.	Months Days	Hours	Min.	Aug 1,	iy, 199 7	32 °	ountry) MD	
	nd how at	Be Completed by Funeral Director	Usual Residence of I 10a. State	Decedent 10b. County Loudoun		10c. City	, Town or Loc	ation						10d. Inside City Limits	
	daryla 8a-f s tified		VA	Loudoun	Tell Forts	Lee	esburg							1 ☐ Yes 2🔀 No	
	a or 2 be no		10e. Street and Num					10f. Zip Code	0.0	175		_	itizen of What C	•	
	th with ms 23 must		17479 Dry	Mill Rd.		F	140.11	21075		175	5. Var. as Na		nited St		
(0	er dea or itel niner		11. Marital Status1 \(\sum \) Never Marrie	ed 2 Married	12. Was Decedent Armed Forces? 1 Yes 2 3			as Decedent of Hi Yes, specify Cuba	spanic Origir n, Mexican, l	n? (Speci Puerto Ri	ty tes or No- can, etc.)		14. Race - Am Black, Whi		
93	ırs aftu ural", IExar		3	Divorced	If Yes, Give Year or Dates.		1	☐ Yes 2 XNo	Specify:				Specify: Wi	nite	
15-(72 hou "nati ledica		(Spec	15. Decedent's Ed cify only highest gra			(Give k	ent's Usual Occupa ind of work done o		of working	7	16b. ł	Kind of Business	s Industry	
712	vithin liene. rr thar the M		Elementary/Seco	nday (0-12)	College (1-4 or	5+)		NOT use retired) Handler	:			Maı	riott (Catering	
nd	filed val Hyg		17. Father's Name (F								First, Middle,		Surname)		
ylaı	permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Impordant: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at one.		Emory Syl						Laura	Ann	Adams			-	
Mai			19a. Informant's Nar Robert M.		· · ·		1	g Address (Street a Dry Mill				-		7ip Code) 20175	
ē,	1 and of Hea item		20a. Method of Dispo	osition		20b. PI	lace of Dispos	ition (Name of		Da			ocation - City o		
imo	Page ment c ant: If ury or		1 ☐ Burial 2 ☐ 4 ☐ Donation	Cremation 3 ☐ 5 ☐ Other (Specify)	Removal from State			atory or other plac cematory	1	2-15	-2009	Har	nover, N	MD	
Baltimore, Maryland 21215-0036	permit. Depart Import any inj		21. Signature of Fun	eral Service License	When	M010								mily FH Inc. , MD 21043	
			23a. Part 1. Enter the shock, or heart	e disease, or comp	lications that cause ne cause on each lin	d the death e.	. Do not enter	the mode of dying	g, such as ca	ardiac or	respiratory ar	rest,		Approximate Interval Between	
	Pnysician/ Medical		Immediate Cause (F disease or condition resulting in death)		a. 525	251	2							Onset and Death	
and the same	Examiner	ner	resulting in death)	ſ	Due to (or	a consequ	ence of):	on atten	ii.						
	outed nd ransit		Sequentially list conditions, if any, leading to immediate Due to (or as a consequence of):												
		Examiner	cause. Enter Underl Cause (Disease or ii that initiated events	njury	C. ————————————————————————————————————										
	iath certificate be executed attending physician and for use as the burial-transit	cal E	resulting in death) Last Due to (or as a consequence of):												
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89 x	ending r use a	Physician/M	IF FEMALE: 23b. Was decedent p	Jognani	ncy I death 3 🗌	ath 3 ☐ Ectopic pregnancy					23d. Date of d	elivery			
P.O. Box 68	he death y the att iched foi		in the past 12 m 1 ☐ Yes 2 ☑ 9 ☐ Unknown		4 Pregnant a 9 Unknown			Other (specify)					Month	Day Year	
P.0	requires that the des been signed by the s should be detached	þ	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contributing to death but not resulting in the underlying cause given in Part I. 1 Yes 2 No 3												
rds,	equire een sig	eted	- Gnd	Stad	e Ren	oi/	dis	ease						Probably 4 Unknown	
ooe	has b	₽ B									24a. Was autor		24b. Were a prior to death?	utopsy findings available completion of cause of	
Ž	rsician: The law r s certificate has b lirector, page 2 s		25. Was case referred	d to medical				26 Pla	ace of Death	Check	1 🗆 Yes	2 🗹 N	lo 1 🗆 Ye	es 2 🗆 No	
Zits	nysicie lis cert direct		examiner? 1 \sum Yes 2 \subset	No F	lospital:	ient 2 🗆 t	ER/Outpatient	Othe	or.			dence (6 Other (Spe	ecify)	
Division of Vital Records,	lospital or Attending P 4 hours after death. inneral Director: After ti ed filled in by the funera		27. Manner of Death 1 Natural 2 Accident	5 Pending Investigation	ry 28b. Time of 28c. Injury at work? M 28c. Injury at work? 1 □ Yes 2 □ No			- 1	28d. Describe how injury occurred						
ivisio			3 ☐ Suicide 4 ☐ Homicide							(Street and Number or Rural Route Number, wn, State)					
Ω		Medical	29a. Certifier (Check (Check 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.									cause(s) and manner stated.			
	To the Nathin 24	Ž	only one) 3		e Practioner: To the	pest of my	knowledge, d	29c. License		and place,	and due to th		s) and manner a ate signed <i>(Mon</i>		
			D	207	MB			360	417			12	-15-6	9	
			30. Name and address	4	ompleted cause of c	death (Item	23a) (Type, Pr	rint)		1/4/2	lem'cle	٠.	10 21	70)	
State 31. Date filed (Month, Day, Year) 32. Jegistrar's Signature															
	Registra		-	APPLY TO TO	THE PERSON		M. Jugo G	4. Ma							

			1 - State of Maryland / Department / Departme	artment of Health and Mer tificate of Death	ntal Hygien	e 2009 4268
			Registrar 1. Decedent's Name (First, Middle, Last)	inidate of Death.	Reg. N	3. Time of Death
	Physicia		ELIZABETH H. MAGEE		DECEMBE!	R 12 2009 5:37 PM
en.	Medic Examin		4a. Facility Name (if not institution, give street and number)	4b. City, Town, or Location of Death		Ic. County of Death
			3600 RIVIERA STREET	TEMPLE HILLS		PRINCE GEORGE'S
	Funeral		5. Social Security Number 6. Sex 7. Age (In yrs. last birthday)		Date of Birth	9. Birthplace (State or Foreign
	Director		259-42-8606 1 M 2 XF 75 Yrs.	Months Days Hours Will.	(Month, Day, Year,	1934 GEORGIA
	nd how at	<u> </u>	Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Loc	eation		10d. Inside City Limits
	laryla 3a-f s ified	Director	MD PRINCE GEORGE'S TEMPLE H	ITITC		1 √2 Yes 2 □ No
	or 28	قَ	10e, Street and Number	10f. Zip Code	10g. (Ditizen of What Country?
	with \$ 23a ust b	Funeral	3600 RIVIERA STREET	20748	Ţ	JSA
	item:		11. Marital Status 12. Was Decedent Ever in U.S. 13. V	Vas Decedent of Hispanic Origin? (Specify Yes, specify Cuban, Mexican, Puerto Ricar	Yes or No-	14. Race - American Indian,
36	", or	þ	1 Never Married 2 Married 1 Yes 2 No	Yes 2 No Specify:	in, etc.)	Black, White, etc.
Ö	ours a	Completed	3 X Widowed 4 Divorced Year or Dates.			Specify: DLACK
45	72 ho n "na Aedio	nple	15. Decedent's Education 16a. Deced (Specify only highest grade completed) (Give k	lent's Usual Occupation kind of work done during most of working O NOT use retired)	16b.	Kind of Business Industry
77	vithin iene.	3	Elementary/Seconday (0-12) College (1-4 or 5+) S+ AC	CCOUNTANT		PRIVATE
þ	iled v Il Hyg othe	B	17. Father's Name (First, Middle, Last)	18. Mother's Name (First		
/lar	d be i Vienta arked	욘	FAITH HODGES	ALBERTA	WALTERS	5
Mar	2 shoul th and I 27 is ma trauma			g Address (Street and Number or Rural Rou RIVIERA STREET TEMP		
altimore, Maryland 21215-0036	permit. Page 1 and 2 should be filed within 72 hours after death with the Manyland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.	8	20a. Method of Disposition 20b. Place of Disposi			Location - City or Town, State
<u>ï</u>	Page nent ant: I		4 Departies 5 Other (Passife)	TION CEMETERY 12/23/	2000 CT	INTON MARYLAND
Salt	permit. Depart Import any inj			Manager and A. Laborer of E. 1994		INS FUNERAL HOME
Ω	70 E # 9	5 7	7	474 LANDOVER ROAD L		
			23a. Part 1. Enter the disease, or complications that caused the death. Do not ente shock, or heart failure. List only one cause on each line.	r the mode of dying, such as cardiac or res	spiratory arrest,	Approximate Interval Between
4	nysician/	1 9	Immediate Cause (Final disease or condition DEMENTIA			Onset and Death
	Medical Examiner		resulting in death) Due to (or as a consequence of):			
		er	Sequentially list conditions, b. <u>HYPERTENSION</u>			
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	xecut n and al-trar	Еха	that initiated events c. Due to (or as a consequence of):			
09	death certificate be executed ne attending physician and ed for use as the burial-transit	dical Examiner				
376	ficate I g phys as the	Jed	_ u			
Box 687	eath certifica attending pl	Physician/Me	IF FEMALE: 23b. Was decedent pregnant 23c. If yes, outcome of pregnancy 1	Ectopic pregnancy		23d. Date of delivery
BO	death	sici	1 Yes 2 No 4 Pregnant at time of death 5	Other (specify)		Month Day Year
P.O.	es that the des signed by the a be detached f	Phy	a 🗆 Olikilomii			
ت .	es tha ignec be de		Part II. Other significant conditions contributing to death but not resulting in the un	iderlying cause given in Part i.		use contribute to the cause of death?
rds J	require been sign	Completed by			1 ∐ Yes 2	No 3 Probably 4 Unknown
00	has b e 2 sh	nple			24a. Was an autopsy	24b. Were autopsy findings available prior to completion of cause of
æ ,	t The				performed?	death? No 1 Ves 2 No
ita	sician certif recto	Be	25. Was case referred to medical examiner? Hospital:	26. Place of Death (Check only Other:		
<u>`</u>	or Attending Physician: The la after death. Director: After this certificate he in by the funeral director, page	일 ::	1 Yes 2 X No 1 Inpatient 2 ER/Outpatient 27. Manner of Death 28a. Date of injury 28b. Time of	1 3 □ DCA 4 □ Nursing Home	5 A Residence Describe how inju	
ם י	nding tth. : Afte	Certificate:	1 ☒ Natural 5 ☐ Pending (Month, Day, Year) injury 2 ☐ Accident Investigation	work? M 1 □ Yes 2 □ No	Describe now inju	ry occurred
isic	or Attend after death Director: A in by the fi	ırtifi	3 Suicide 6 Could not be 4 Homicide determined 28e. Place of Injury - At home, farm, streen		Location (Street a	nd Number or Rural Route Number,
Division of Vital Records,	tal or		building, etc. (Specify)		City or Town, State	э)
	Io the Hospita or Attending Physician: The law requires that the within 24 hours after death. To the Funeral Director After this certificate has been signed by the completed filled in by the funeral director, page 2 should be detach.	Medical	29a. Certifier (Check (Check 2 Medical Examiner: On the bast of my knowledge, death or 2 Medical Examiner: On the basis of examination and/or investigation.	ocured at the time, date and place, and due	e to the cause(s) a	and due to the cause(s) and manner stated
:	Io the Hos within 24 h To the Fun completed	Me	only one) 3 L Certifying Nurse Practioner: To the best of my knowledge, do	eath occurred at the time, date and place, and	d due to the cause	(s) and manner as stated.
	5.≱ 6 8		29b. Signature and title of certifier	29c. License number	29d. Da	ate signed (Month, Day, Year)
			20 Name and Advance of pages with a small to the state of	H66665	DH	ECEMBER 22, 2009
2	5		30. Name and Address of person who completed cause of death (Item 23a) (Type, Pr DONA LESKUSKI M.D. 9200 BASIL COUR	·	ΜΑΡΥΙ ΔΝΙ	20774
	Stat	е	31. Date filed (Month, Day, Year)	LI DOLLI 200 LARGO,	THINT DAME	, 40//7
	Registra	ır	DEC 2 3 2009 Cenera D. Jake			

State of Maryland / Department of Health and Mental Hygiene

			1 - State Of a State O	•	ertificate of Death		ene g. No. 2 N N C	1,2682
I	Physici	an	1. Decedent's Name (First, Middle, Last)	Manua 1		2. Date of Death Month	Day Year	3. Time of Death
. 4	/Medic		Emma Luci11e 4a. Facility Name (If not institution, give street and numbined)		4b. City, Town, or Location of De	Dec 22,	2009 4c. County of Dea	7:13 A M
	LAMINI	CI	8705 Pinta Street	,	Clinton		Prince (George's
	Funeral Director		5. Social Security Number 213 48 6336 Usual Residence of Decedent 6. Sex 1 M 2 T F 7.	Age (In yrs. last birthday, 91 Yrs.) If Under 1 Year If Under 24 F Months Days Hours M	in (Month, Dav.	Ye <i>ar)</i> 9. Bir Co L 91 8 Mar	thplace (State or Foreign ountry) yland
	yland how		10a. State 10b. County	10c. City, Town or Le	ocation			10d. Inside City Limits
	ne Mai 18a-f s	ecto	MD Prince George	's Clinton				1 □ Yes 2XXNo
	with th	Funeral Director	10e. Street and Number 8705 Pinta Street		10f. Zip Code 20735	10	g. Citizen of What Co United S	
	death	nera	11. Marital Status 12. Was Decede	nt Ever in U.S. 13.	Was Decedent of Hispanic Origin? If Yes, specify Cuban, Mexican, Pu	(Specify Yes or No-	14. Race - Ame	erican Indian,
Baltimore, Maryland 21215-0036	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Evantine Intelligent anone.	d by Fu	1 Never Married 2 Married 1 1 Yes 2 1 1 Yes, Give 3 M Widowed 4 Divorced Year or Date	XI No	1 ☐ Yes 2 ☐ No Specify:	erto Hican, etc.)	Black, White	
15-(n 72 h n "natu	Be Completed by	15. Decedent's Education (Specify only highest grade completed)	(Give	edent's Usual Occupation e kind of work done during most of v DO NOT use retired)	vorking 1	6b. Kind of Business	/Industry
212	d withi giene. er thar	Som	Elementary/Secondary (0-12) College (1-4c)	3f 5+1 I	Homemaker Domest		Domesti	С
pug	be file ntal Hy ed oth	Be (17. Father's Name (First, Middle, Last) Thomas Eugene Latimer			lame (First, Middle, Ma		
ij	should nd Mei marke imatic	2	19a. Informant's Name/Relationship (Type. Print)	19b. Mail	ال ing Address (Street and Number or		DeMarr City or Town State	Zip Code)
ĭ.	and 2 sealth a		Barbara Patterson (Daugh		O5 Pinta Street,			p
ore	ges 1 at of He If item or oth		20a. Method of Disposition 1 XXSurial 2 □ Cremation 3 □ Removal from Sta	ile i	osition (Name of ematory or other place)		0c. Location - City or	
<u>#</u>	artmen ortant: Injury		4 ☐ Donation 5 ☐ Other (Specify) 21. Sign flure of 5 neral Service Lice	Cedar H	$ ext{Hill Cemetery}; 12,$ 22. Name and Address of Facility $ extstyle ext{L}$			
Ba	permi Depa Impo any ir		1 Toget Mason	010	Alexandira Ferry		•	20735
	Physician		23a. Part 1. Enter the disease, or complications that caus shock, or heart failure. List only one cause on each Immediate Cau e (Find disease or condition	sed the death. Do not en	ver the mode of dying, such as card	diac or respiratory arres	st,	Approximate Interval Between Onset and Death
profession and	/Medical Examiner		resulting in death) Due to (or	as a con quence of):	Att. Dinas			
		Jer	Sequentially list conditions, if any, leading to immediate Due to (or	as a consequence of):	TIMM VISUAL			
	ecuted ind transit	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	Hyperten	sin 2			
68760,	rificate be executed ng physician and as the burial-transit		Due to (or s	as a consequence of)	N .			
687	tificate ig phys as the	Medical	d	3 CHORECO (I)	~			
O. Box	The law requires that the death certificate be executed ate has been signed by the attending physician and bage 2 should be detached for use as the burial-transit	by Physician/IV		h 2 ☐ Fetal death 3 [it at time of death 5 [☐ Ectopic pregnancy ☐ Other (specify)		23d. Date of de Month	livery Day Year
σ.	that the	y Ph	Part II. Other significant conditions contributing to death	າປout not resulting in the ເ	underlying cause given in Part I.	23e. Did toba	acco use contribute to	o the cause of death?
Records,	w requires that s been signed t should be deta		Marmishala	Ī		_ 1 □ Yes	3 2√∑ No 3 □ P	robably 4 🗌 Unknown
Sec	e law re has be ie 2 sho	Completed	Alzheimens	Disease.		24a. Was an autopsy	prior to	utopsy findings available completion of cause of
<u>e</u>	Physician: The la this certificate ha ral director, page 2		0			perform	ed? death?	s 2 🗆 No
\equiv	ysicia is certi directo	o Be	25. Was case referred to medical examiner? 1 Yes 2 No Hospital:	atient 2 ☐ ER/Outpatie	Othor	Death <i>(Check only one)</i> g Home XX Residen		aciful
Division of Vital	ding Ph h. After th funeral	D:T	27. Manner of Death 28a. Date of I			28d. Describe how		sciryy
Sio	Nttendi death. ctor: A y the fu	icati	2 Accident investigation	Injury At home form of	M 1 □Yes 2 □No	006 Location (Otro		out On to Mountain
<u>≥</u>	spital or At ours after d neral Direct filled in by	Certification: T	4 Homicide determined building,	Injury - At home, farm, streetc. (Specify)	reet, lactory, office	City or Town,	eet and Number or R State)	urai Houte Number,
	Hospi 4 hou Funer tely fil	Medical C	29a. Certifier (Check only one) Check only one) Check only one) Certifying Physician: To the be 2 Medical Examiner: On the basis and manner	s of examination and/or ir	th occurred at the time, date and pl nvestigation, in my opinion, death o	ace, and due to the ca ccurred at the time, dat	use(s) and manner a te and place, and du	s stated. e to the cause(s)
	To the within 2 To the comple	Σ	29b. Signature and title of certifier	000	29c. License number	() 296	d. Date signed (Mont	th, Day, Year)
			30. Name and address of person who completed cause o	f death (from 92a) (Time	Y 23826	(my)	12/22/	09
7/1	0		Dr. Edgecombe, 7700 Old B			on, MD 20	735	
	Stat Registra	te ar	31. Date filed (Month Day, Year) 32. Regis	otrorio Ciamaturo	backer			

DHMH 17 Rev 1/2001

State of Maryland / Department of Health and Mental Hygiene 🤈 42683 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** Month December 2009 11:55 AM Harry Omar Meyers, Jr. /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City. Town, or Location of Death **Examiner** 16705 Tammany Manor Road Williamsport Washington If Under 1 Year | If Under 24 Hrs.

Months Days Hours Min. Birthplace (State or Foreign Country)
 Maryland 5. Social Security Number 8. Date of Birth (Month, Day, Year)
Dec. 15, 1935 6. Sex 7. Age (In yrs. last birthday) **Funeral** Days Months 1**X** M 2□ F Director 220-28-8934 74 Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits 7 is marked other than "natural", or items 23a or 28a-f show traumatic event, If y Madical Examiner must be notilied at Director 1 ☐ Yes 2 X No Maryland | Washington Williamsport 10f. Zip Code 10e. Street and Number 10g. Citizen of What Country? 16705 Tammany Manor Road 21795 USA Funeral death 12. Was Decedent Ever in U.S. Armed Forces? 1 ₩Yes 2 □ No 1954 If Yes, Give Year or Dates: 1956 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. 11. Marital Status 2 No 1954 filed within 72 hours after 1 ☐ Never Married 2 X Married altimore, Maryland 21215-0036 1 ☐Yes 2 No White Specify ģ Specify: 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) and Mental Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) Hourly Benefit Representative Auto Parts Distribution 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be 1 and 2 should be Harry Omar Meyers Mildred Pearl Myers ပ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Pages 1 and 2 s
Department of Health as
Important; If item 27 is
any injury or other trau Esther A. Meyers - Wife Williamsport, MD 21795 16705 Tammany Manor Road 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Date 1 N Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Greenlawn Mem. Park 12-23-2009 Williamsport, Maryland 21. Signature of Funeral Crys 22. Name and Address of Facility Osborne Funeral Home, P.A. 425 S.Conococheague St. Williamsport, MD 21795 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician disease or condition resulting in death) 10 Year /Medical n. Due to for as a consequince Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to (or as a consequence of burial-transi and Due to (or as a consequence attending physician for use as the burial Box 68760. certificate be Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy

1 Live birth 2 Fetal death
4 Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months? 3 Ectopic pregnancy Month Day Year 5 ☐ Other (specify) 0 ☐Yes 2 ☐ No detached 9 Unknown 9 Unknown · ph Ф. signed b by but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Records, 2 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown plnous Completed 24b Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☐ No 24a. Was an has page 2 autopsy performed? Yes 2 No the Hospital or Attending Physiclan: The hin 24 hours after death. the Funeral Director: After this certificate ripletely filled in by the funeral director, pag of Vital | 1 □Yes 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 1 Tyes မ 1 Inpatient 2 ER/Outpatient 3 DOA 6 ☐ Other (Specify) 27. Mann f Death 1 Natural 28a. Date of Injury (Month, Day, Year) 28b. Time of 28d. Describe how injury occurred Certification: Division 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 3 🗌 Suicide 6 ☐ Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) Medical 29a. Certifier (Check only one) within 2 To the 29b. Signatuse 29d. Date signed (Month, Day, Year) License number MUE 3665 Dec. 21 2000 MP 3114 Samuel 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Chan SINOT. 02H7+1 m.D. 31. Date filed (Month, 32. Registrar's Signature Day, Year) State Registrar

ORIGINAL

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 42684 Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Excember. Marguerite Virginia Newcomer Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death Washington County Hospital Hagerstown Washington Social Security Number 7. Age (In vrs. last birthdav If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year)
Aug. 21, 9. Birthplace (State or Foreign **Funeral** 1 M 2 X Months Davs Hours Min. 182-22-6849 Director 81 Maruland Usual Residence of Decedent fshow 10a. State 10b. County Page 1 and 2 should be filed within 72 hours after death with the Maryland ed other than "natural", or items 23a or 28a-f sho event, the Medical Examiner must be notified at 10c. City, Town or Location 10d. Inside City Limits Director 1 🗆 Yes 2 🔀 No Maryland Washington Hagerstown 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 14147 Poplar Grove Road 21742 USA 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S 11. Marital Status 14. Race - American Indian Armed Force Completed by 1 Never Married 2 Married ☐ Yes 2 🔀 No Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☑ No Specify: If Yes, Give White 3 ☒ Widowed 4 ☐ Divorced Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business Industry (Specify only highest grade completed) Health and Mental Hygiene. Elementary/Seconday (0-12) College (1-4 or 5+) Executive / Vice President Courier Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) William Weaver Bertha Hose 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) (Daughter) Nancy L. Poole 14147 Poplar Grove Rd. Hagerstown, Maryland 21742 item 20a, Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Date Important: If it any injury or o 1 X Burial 2 Cremation 3 Removal from State December Ringgold, Maryland Ringgold Cemetery 4 ☐ Donation 5 ☐ Other (Specify) 28, 2009 Signature of Funeral Service Licenses J.L. Davis Funeral Home MO1414 22. Name and Address of Facility 12525 Bradbury Ave. Smithsburg, Maryland 21783 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final NTRACRAN Physician disease or condition resulting in death) Medical D e to (or as a consequence of): Examiner TROMBOLY IT Sequentian, liet conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or linjury Due to (or as a consequence of) Exam attending physician and for use as the burial-transi EREBROVASCU that initiated events Due to (or as a consequence of) resulting in death) Last Physician/Medical IE EEMALE 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy 5 Other (specify) ___ in the past 12 months?

1 Yes 2 No 4 Pregnant a Day Pregnant at time of death 1 Yes 2 Unknown ed by the a detached f Division of Vital Records, P.O. signed k Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ò DIAGETER 2 No 3 ☐ Probably 4 ☐ Unknown Completed 1 🗌 Yes page 2 should been 24b. Were autopsy findings available prior to completion of cause of death?

1 Yes 2 No 24a. Was an has To the Hospital or Attending Physician; The law autopsy certificate 25. Was case referred to medical 26. Place of Death (Check only one) Be examiner? 2. No မ Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) After this within 24 hours after death.

To the Funeral Director: After thi completed filled in by the funeral 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at Certificate: 28d. Describe how injury occurred work? 1 🗆 Yes 2 🗆 No 1 Natural 5 \square Pending Accident Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier 2 Hodical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) 12 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) SUITE

DHMH 17 Rev 7/2009

State

Registrar

31. Date filed (Month, Day, Year)

NO72010

32. Registrar's

		,	for State Registrar	State	itarylan		artment of I <i>rtificate of</i>			giene Reg. No. 20	09	42685
	Physici	an	1. Decedent's Name (First, Middle	, Last)		NICKI			2. Date of De	ath Day		3. Time of Death
	Physici /Medi		ELIZABETH]	LEE	NIKE	RSON		DECEM	IBER 15	2009	5:40 P M
	Examir	ner	4a. Facility Name (If not institution	-			•	or Location of Dea	ith	4c. County	of Death CE GEO	DCF†S
-6	Funeral		PRINCE GEORGE 5. Social Security Number	6. Sex	7. Age (In yrs.	last birthdav)	If Under 1 Year	If Under 24 Hr	8. Date of Bir		9. Birtholac	e (State or Foreign
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	f shor	ō			100. CII	ty, Town or Lo					100.	1. Tiside City Limits
	the A	Director	DC 10e. Street and Number			WASHIN	10f. Zip Code			10g. Citizen of V	What Country	Λ
	h with	af Di	4909 FOOTE STRE	ET N.E.			20019			USA		
	ems %	Funeral	11. Marital Status	12. Was Dec	edent Ever in U.	.S. 13.	Nas Decedent of f Yes, specify Cub	Hispanic Origin? ((Specify Yes or No	14. Rac	e - American ck, White, etc.	
36	s 1 and 2 should be filed within 72 hours after death with the Maryland of Health and Mental Hygiene. Item 27 Is marked other than "natural", or items 23a or 28a-f show other traumatic event, the Middel Examiner is ust be rediffed at	by Fu	1 ☐ Never Married 2 ☐ Marri ③ Widowed 4 ☐ Divorced	ed 1 □Yes If Yes, Gi	2 ∑No ve		I∐Yes 2⊠No	Specify:	,	Specify		BLACK
5-0036	hour tural	ed k	15. Decedent	Year or E	ates:	16a, Dece	dent's Usual Occu	pation		16b. Kind of Bu	usiness/Indus	strv
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ž	should be f and Mental s marked o	ပ	CLARENCE WATSON			405 Mailin	A-I-I (Cà				Ctata Zin Co	a da l
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altimore,	s 1 and 2 of Health item 27 I	1	20a. Method of Disposition	IN-CRAWF	20b. F	Place of Dispo	Sition (Name of natory or other pla	1	Date	20c. Location -		
Ē	Pages nent of hant of hant; if ite		1 □Xurial 2 □ Cremation 4 □ Donation 5 □ Other (Sp						/23/2009	BRENTWO	OD, MAR	YLAND
	permit. Pages Department of Important: If it any injury or o		21. Signature of Funeral Service I	icensee	Λ		. Name and Addr	•		TENRINS		
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68760	death certificate be executed e attending physician and d for use as the burial-transit	edical	·	d								
×	eath certific attending p for use as		IF FEMALE: 23b. Was decedent pregnant	23c. If yes, ou	tcome of pregna	ancy				23d Da	te of delivery	
Box	death e atte d for u	Physician/M	in the past 12 months? 1 ☐ Yes 2 ☐ Xio	4 ☐ Preg	birth 2□ Feta nant at time of c		Ectopic pregnan Other <i>(sp</i> ec <i>ify)</i> _	су			onth Da	
<u>Р</u>	at the de by the a	hys	9 🗆 Unknown	9 □ Unkr	nown							
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0	w requir s been s should	sted							- 1	Yes 21X1No	3∐ Probab	ly 4 🗌 Unknown
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a	sician: The L certificate ha rector, page 3		OF Miss are referred to read the						1 □ Yes	2 X No	1 ☐ Yes 2]	No
Ξ	/sicia s cert directo	o Be	25. Was case referred to medical examiner? 1 Yes 2 No	Hospital:	Inpatient 2 🗆	i⁄EB/∩utpatier	t 3 DOA Ot	or.	eath (Check only only only only only only only only		or (Charify)	
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Š	or Att	ertification:	3 ☐ Suicide 6 ☐ Could n 4 ☐ Homicide determi	ned 28e. Place build	of Injury - At ho ing, etc. (Specif	ome, farm, str (y)	eet, factory, office		28f. Location (City or To	Street and Numb wn, State)	per or Rural R	loute Number,
	pital ours a eral c	O	29a. Certifier 1 🔀 Certifying	Physician: To the	hant of my kno	wlodgo dost	a accurred at the t	imo data and ala	as and due to the	course(s) and m	annor as stat	tod.
	To the Hospital or Attending Physician: within 42 hours after death. To the Funeral Director. After this certifical completely filled in by the funeral director, to the funeral director.	edical		xaminer: On the b								
	To the within To the compl	Me	29b. Signature and title of certifier		5/00-1		29c. Licen	se number		29d. Date signe	d (Month, Da	y, Year)
			1 /- 10	so was	/ (~ /		D	30509		DECEMB	ER 18,	2009
)	5		30. Name and address of person v				Print)		TON DO	20002		
_			GODSWILL OKOS 31. Date filed (Month, Day, Year)				DAD N.E.	WASHING	TON, DC	20002		
	Sta Registr	_	DEC 2 2 2009	house	Registrar's Signa	all						

DHMH 17 Rev 1/2001

			1 - For AMEND#236,26,30,	State of M perMD 12/18	laryland My, EM	, Depa Cer	rtment of F <i>tificate of l</i>	lealth and D <i>eath</i>	Mental Hyg	iene 19. No. 2005	42686
	~		1. Decedent's Name (First, Middle, Las	st)					2. Date of Death	Day Year	3. Time of Death
	Physicia Medic/			Maria Li	uz Nur	rez			Decembe		8:20 pm
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an sol			Lu Familio 5. Social Security Number 6. S		are the room to	a de la	If Under 1 Year	ckville	8. Date of Birth	Montg	hplace (State or Foreign
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	pui w		Usual Residence of Decedent 10a. State 10b. County		10c City	, Town or Lo	cation				10d. Inside City Limits
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	the h	Director	Maryland Mont	gomery			10f. Zip Code	Rockvil		ng. Citizen of What Co	untry?
	h with		14109 Manoru	ale Road				20853		Per	и
	ems;	Funeral	11. Marital Status	12. Was Decedent Armed Forces		3. 13.	Was Decedent of H	ispanic Origin? (Specify Yes or No- rto Rican, etc.)	14. Race - Ame Black, White	
36	be filed within 72 hours after death with the Maryland ttal Hygiene. Id other than "natural", or tiems 23a or 28a-f show event, I'm Mydical Evaria har must be maithed at	by Fu	1 ☑ Never Married 2 ☐ Married 3 ☐ Widowed 4 ☐ Divorced	1 ∐Yes 2 🛛 If Yes, Give Year or Dates:] No		Yes 2□No		ruvian	Specify:	White
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Maryland	hould d Mer marke matic	욘	Adokh	o Nunez		10h Mailir	ng Addrona (Street			on de Nune City or Town, State, .	
B S	nd 2 s Ith an 27 is r r trau		Amelia De Lucio		ħ	1				le, Maryla	
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Baltimore,	permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show amy injury or other traumatic event, It. M. Alcal Evan, increase in multilad anone.		21. Signature of Furt rat Service Licen	see		22	. Name and Addre	ss of Facility S .	imple Tri	bute & Cre	mation Ctr.
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CO	w requir been s	lete	•	*					24a. Was a	n 24b. Were a	utopsy findings available
æ	The law te has age 2 :	Completed				-	- "		autops perforr	y prior to death?	completion of cause of s 2 □ No
<u>ta</u>	ician; The certificate ector, pag	e e	25. Was se referred to medical examiner?			1		26. Place of De	1 □Yes 4 eath <i>(Check only n</i>		2 - 140
<u></u>	hysic his ce I direc	To B	exammery 1 ☑ Yes 2 ☐ No	Hospital: 1 ☐ Inpat	tien t 2	ER/Outpation	++-3 □ DOA Oth	er: 4 🗆 Nursing	Home 5 Reside	ence 6 Other (Spe	ecify)
Division of Vital Records,	ding Physician: The n. After this certificate hi funeral director, page	ion:	27. Manner of Death 1 ☑ Natural 5 ☐ Pending	28a. Date of In (Month, D	jury Jay, Year)	28b. Time o Injury	Wor	ί? 	28d. Describe ho	w injury occurred	
<u>is</u>	or Atteno after death Director:	ficat	2 ☐ Accident investigation 3 ☐ Suicide 6 ☐ Could not be		niury - At ho	me. farm. str	M 1 □ eet, factory, office	Yes 2 □ No	28f. Location (St	reet and Number or Fi	ural Route Number.
<u>≥</u> .	al or A after I Direct	Certification: To	4 ☐ Homicide determined	building, e	etc. (Specify	<i>'</i>)	001, 140101), 011100		City or Town		
	To the Hospital or Attending Physician: within 24 hours after death. To the Funeral Director: After this certifica completely filled in by the funeral director, to the funeral director.	Medical (of examinat					ause(s) and manner a ate and place, and du	
	To the company of the	Me	29b. Signature and title of certifier	7010 A YU	INUI M	1)	29c. Licens		2	9d. Date signed (<i>Mon</i>	
	-		30. Name and address f person who	completed cause of	death (Item	23a) (Type,	Print)				
		11 ()	Jose A. Quiros, M.D.	4343 Monto	pomery A	Avenue;	Bethesda,	MD 20814			
	Sta Registr		31. Date filed (Month, Day, Year) DEC 17 2009	2. Hegis	mai s Signat	bau	المدا				
			DEC A C ZOU:	J. JENES	-						

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 42687 State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ 2009 December 8:00 a M Eileen Theresa Nicosia Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death Rockville Nursing Home Rockville Montgomery 5. Social Security Number If Under 1 Year If Under 24 Hrs. 7. Age (In vrs. last birthday) 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** 1 □ M 2 🗓 F Months Days Hours Min. Month, Day, Year, SEP 29 1 Director 081-34-7109 66 SEP Usual Residence of Decedent 27 is marked other than "natural", or items 23a or 28a-f show traumatic event, the Medical Examiner must be notified at 10b. County 10c. City, Town or Location 10d. Inside City Limits Director MD Montgomery Bethesda 1 Yes 2 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 5213 Falmouth Road 20816 United States 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 🛣 No Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11 Marital Status 14 Race - American Indian Black, White, etc. by 1 Never Married 2 X Married 1 Yes 21215-0036 1 ☐ Yes 2X No Specify: Specify: Caucasian 3 Divorced 4 Divorced Completed Year or Dates 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) US Dept. of Education/ Elementary/Seconday (0-12) College (1-4 or 5+) Mental Hygiene. Legislative Assistant/Painter Self Employed Be Baltimore, Maryland 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ပ္ Philip. Nicosia **Blanche** Valero permit. Page 1 and 2 should Department of Health and M Important: If item 27 is mar any injury or other traumat 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Charles H. Cash / Husband 5213 Falmouth Rd, Bethesda, MD 20816 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Date 1 Burial 2 X Cremation 3 Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Atlantic Crematory 12/15/2009 Glen Burnie, MD Signature of Funeral Service Licensee 22. Name and Address of Facility Thibadeau Mortuary Service, P.A. M00956 Park Avenue, Gaithersburg, 23a. Part 1 Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between Onset and Death shock, or heart failure. List only one cause on each line Immediate Cause (Final Physician/ disease or condition resulting in death) CREUTZFELT JACOB DISEASE Medical Due to (or as a consequence of) Examiner RESPIRATORY FAILURE Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or linjury Due to for as a consequence of, Examir DEMENTIA burial-tran that initiated events resulting in death) Last Due to (or as a consequence of) Physician/Medical the 듄 for use as IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?

1 Yes 2 No Month Day Pregnant at time of death 5 Other (specify) 1 ☐ Yes 2 ▲ 9 ☐ Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by cate has been signe page 2 should be Records, 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4X Unknown 24b. Were autopsy findings available prior to completion of cause of 24a. Was an autopsy performed? Yes 2 X No death?
1 Yes 2 No **Division of Vital** upleted filled in by the funeral director, Be 25. Was case referred to medica 26. Place of Death (Check only one) examiner? Hospital: Other: 4 🔀 Nursing Home 5 🗆 Residence 6 🗀 Other (Specify) ၉ 2 🔀 No 1 Inpatient 2 ER/Outpatient 3 DOA 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of 28c. Injury at work? 1 ☐ Yes 2 ☐ No Certificate: 28d. Describe how injury occurred Hospital or Attending 1 🕅 Natural iniury 5 Pending Accident Investigation after deat Director: Suicide 6 Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) e Funeral I Medical 1 💢 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. within 2

To the I

complex only one) 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) ၉

State Registrar

SAM

THOMAS V. JOSEPH, M.D., 50 W. EDMONSTON_DR. #207, ROCKVILLE, MD 20852

D0047330

DECEMBER 14, 2009

JUSLAN

Registrar's Signature

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Showing

17

31. Date filed (Month, Day, Year)

DEC

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 2 1. Decedent's Name (First, Middle, Last) 2. Date of Death DECEMBER 13, 2009 **Physician** DOROTHY E. NEIDECKER /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Prince George's Renaissance Gardens at Riderwood Village Silver Spring 8. Date of Birth Jan. 3, 1927 5. Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year | If Under 24 Hrs. 9. Birthplace (State or Foreign **Funeral** Months Days Hours Min. Washington, DC 578-36-2106 82 Director Usual Residence of Decedent death with the Maryland 10a State 10b. County 10c. City, Town or Location 10d. Inside City Limits permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hyglene.

Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once. Maryland Montgomery Silver Spring Director 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 20904 3116 Gracefield Road, #313 United States Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 14. Race - American Indian. 1 ☐Yes 2 ☐ If Yes, Give Year or Dates: 1 Never Married 2 Married 2 **X**No Baltimore, Maryland 21215-0036 White 1 ☐ Yes 2 No Specify: 2 3 Widowed 4 Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Homemaker own home 18. Mother's Name (First, Middle, Maiden Surname) Be 17. Father's Name (First, Middle, Last) Edward G. Boss Lillie M. Loughery ည 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 3116 Gracefield Road, #313 Silver Spring, Maryland 20904 Charles L. Neidecker -husband 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 Burial 2 □ Cremation 3 □ Removal from State Fort Lincoln Cemetery 12/16/2009 Brentwood, Maryland 4 □ Donation 5 □ Other (Specify)

23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Due to (or as a consequence of):

Physician /Medical

> the detached

signed by t I be detach

in 24 hours, the Funeral Director.

within 2

2

cal

Division of Vital Records, P.O. Box 68760,

disease or condition resulting in death) **Examiner** Hospital or Attending Physician: The law requires that the death certificate be executed 24 hours after death. attending physician and

Renal Failure Sequentially list conditions, if any, leading to immediate Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examine Ischemic Colitis Due to (or as a consequence of) Physician/Medical IF FEMALE 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I 2 Rheumatoid Arthritis; Spinal Stenosis Completed 25. Was case referred to medical examiner? Be 1 ☐ Yes 2√ No Certification: To

21. Signature of Funeral Service Licensee

Marial

Immediate Cause (Final

27. Manner of Death

2 Accident

3 Suicide

4 Homicide

(Check only one)

29a. Certifier

23c.	If yes, outcome of pregnancy
	1 Live birth 2 Fetal death
	4 Pregnant at time of death
	O I I Independent

1 Inpatient

28a. Date of Injury (Month, Day, Year)

Sersis

3 Ectopic pregnancy 5 ☐ Other (specify)

Bonald Words Borg Wardt Funeral Home, PA

4400 Powder Mill Road Beltsville, Maryland 20705

23d. Date of delivery

10:31A.M

1 ☐ Yes 2 No

23e. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ XUnknown

24b. Were autopsy findings available prior to completion of cause of death? autopsy performed? Yes 2 2 No 2 No 1 □ Yes 1 ☐ Yes 26. Place of Death (Check only one) oecify)

ther: 4 🕅 Nursing H	lome	5 🗌 Residence	6 ☐ Other (S)
ury at ork?		Describe how inj	
TVos 2 IINo			

24a. Was an

28c. Inju Wo 1 F Location (Street and Number or Rural Route Number, City or Town, State) Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and little of certifie

5 Pending investigation

6 Could not be determined

29c. License number D24035 29d. Date signed (Month, Day, Year) December 15, 2009

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

E.J. Machado, M.D. 3110 Gracefield Road Silver Spring, Maryland 20904

2 ☐ ER/Outpatient 3 ☐ DOA

28b. Time of

Injury

State Registrar

			Plea	se Type or	Print in of Maryla								_	jible.		
			1 - For State Registrar	State	n iviai yiai	•	rtificate			ariu iv	ieniai ny	Reg. N	0.0	119	42	689
	Physicia	an	1. Decedent's Name (First, Middle		_						2. Date of D Month		Day	Year	3. Time	
	/Medic	al	Paul Jerome N 4a. Facility Name (If not institution		umber)		4b. City, To	own or	Location	of Death	Decemb			2009 ty of Death	7:06	P M
•	Examin	er	5408 Fifth Av	enue			Upper	co				3	Baltimore County			
ı	Funeral Director		5. Social Security Number 220–68–1647 Usual Residence of Decedent	6. Sex 1 X M 2 ☐ F	7. Age (In yrs	53 Yrs.	If Under 1 Months	Days	If Under Hours	Min.	8. Date of B (Month, D NOV • 20	pay, Yea	956	9. Birth Cou Mary	place (State ntry) rland	or Foreign
	Maryland a-f show ified at	ctor	10a. State 10b. County Maryland Baltir	nore Coun		ity, Town or Lo	ecation								10d. Inside 1 □ Ye	City Limits s 2∭No
ž	3a or 28 st be not	Funeral Director	10e. Street and Number 5408 Fifth Ave	enue		-	10f. Zip C	Code 155						State	*	
9500-c	permit. Pages 1 and 2 should be flied within 72 hours after death with the Maryland Department of Heath and Mental Hygiene. Important: If tien 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, Ital Modical Evaniner must be notified at once.	by	11. Marital Status 1 □ Never Married 2 ☒ Mar. 3 □ Widowed 4 □ Divorced	ried Armed F	2 Mo ive		Was Decede If Yes, specif 1 □Yes 2	fy Cuba	spanic Ori n, Mexicar Specify:	n, Puerto	ecify Yes or N Rican, etc.)	0-	14. Race - American Indian, Black, White, etc. Specify: white			
0-61713	within 72 no lene. than "natur"	Completed	15. Deceder (Specify only highe Elementary/Secondary (0-12)	t's Education st grade completed College) (1-4or 5+)	(Give	dent's Usual kind of work DO NOT use mobile	done of	luring mos)		ing			Business/Ir	repai	.r
and	ental Hyg ked other ic event, I	To Be C	17. Father's Name (First, Middle, Loren F. Nobl								e (First, Middle A. Wi		en Surna	ıme)		
, mary	and z shou ealth and M n 27 is mar er traumat	F	19a. Informant's Name/Relations Dorothy E. No		ie .	77	ng Address (Ü	al Route Num Ipperco	, Ma	aryla	and 2	1155	
altimore	tment of H tment of H tant: If iter ijury or oth		20a. Method of Disposition 1 ☐ Burial 2 🕱 Cremation 4 ☐ Donation 5 ☐ Other (S	pecify)	State Ca	Place of Dispo cemetery, cree rroll (remat:	ier place ion	i	De	2009	На	mpst		own, State Maryl	and
ם ם	Depar Impor any in	21. Signature of Funeral Service Licensee M01072 22. Name and Address of Facility Eline Funeral M01072 934 South Main Street Hamps											ryland	2107		
	hysician /Medical xaminer		23a. Part 1. Enter the disease, or shock, or heart failure. List Immediate Cause (Final disease or condition resulting in death)	a.	caused the dea each line. h([[])	1c (ter the mode ひんこと		g, such as	cardiac	or respiratory	arrest,)	Approxim Interval B Onset and	etween d Death
ou,		al Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	c	(or as a conse	,										
ol Vital necords, P.O. box 66/60	in requires that the determinate be executed been signed by the attending physician and should be detached for use as the burial-transit	Physician/Medical	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	1 Live	utcome of pregi birth 2 Fe gnant at time of nown	tal death 3	⊒ Ectopic pre ⊒ Other <i>(spe</i>		y	**		-		Date of deli	very Day	Year
cords, r	n signed b	by	Part II. Other significant conditi	ons contributing to	death but not re	sulting in the u	nderlying cau	use give	en in Part I					ntribute to 3 ☐ Pro	the cause o	death? Unknown
מו הפכסו	After this certificate has bee funeral director, page 2 shou	Completed									24a. Wa aut per 1 □ Yes	opsy formed	?	prior to c death?	opsy finding ompletion o	s available cause of
VII	s certif	o Be	25. Was case referred to medica examiner? 1 ☐ Yes 2 ☑ No	Hospital:] Inpatient 2 [☐ EB/Outpatie	nt 3 🗆 DO4	Othe	or:		h <i>(Check only</i> ome 5 Re			other (Spec	rifu)	
	tter 1	tion: T	27. Manner of Death 1	28a. Date (Mo	e of Injury nth, Day, Year)	28b. Time o		c. Injun			28d. Describe					
DIVIS	within 24 hours after death. To the Funeral Director: After completely filled in by the funeral	Certification: To	3 ☐ Suicide 6 ☐ Could 4 ☐ Homicide determ	sined [286. Place	e of Injury - At ding, etc. (Spec	home, farm, sti cify)	reet, factory,	office			28f. Location City or To	(Street own, St	and Nur ate)	mber or Ru	ral Route Nu	ımber,
11000	n 24 hour ne Funera pletely fille	Medical (ng Physician: To the Examiner: On the and ma												e(s)
-	1	Z	29b. Signature and title of certifie	P.	21.00		29c.	License	e number	\neg		29d.	Date sign	.1	, Day, Year)	
	MJL		30. Name and address of person	who completed cau) Vh)	em 23a) (Type,	Print)	06	454	1			10	र्गामार्	14	
		(May L. Rice	. 555 5	auth (aters	troot	(1)	35th11	Wo	OHI	011	57			
8	Sta Registr		31. Date filed (Month, Day, Year)	555 S	Census.	A.	park	1								

Registrar DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registra Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month 3:30 pm 14, December 2009 Peter Hach Nguyen 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Montgomery Manor Care Chevy Chase Chevy Chase 5. Social Security Number If Under 1 Year | If Under 24 Hrs. Months Days Hours Min. 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) 6. Sex 7. Age (In yrs. last birthday) Months 1 ☑ M 2 ☐ F 82 June 01, 1927 Vietnam 586-30-4778 10a. State 10c. City, Town or Location 10d. Inside City Limits 10b. County 1 X Yes 2 No Silver Spring Maryland Montgomery 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 20901 808 Heron Drive u.s.A. 12. Was Decedent Ever in U.S. Armed Forces? 14. Race - American Indian Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Black, White, etc. 1 ☐ Yes 2 ☑ If Yes, Give Year or Dates: 1 ☐ Never Married 2 ☑ Married 2 No 1 ☐ Yes 2 X No Specify. Specify: 3 Widowed 4 Divorced Asian 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Technician Medical 12 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Vinh Nguyen Cham Ta 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Nga Nguyen - Daughter 12 Feather Rock Place, Rockville, Maryland 20850 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 XI Burial 2 ☐ Cremation 3 ☐ Removal from State 12/21/2009 Silver Spring, MD 4 ☐ Donation 5 ☐ Other (Specify) Gate of Heaven Cem. 22. Name and Address of Facility Hines-Rinaldi Funeral Home, 21. Signature of Funeral Ogrvice License 11800 New Hampshire Ave., Silver Spring, MD 20904 M01294 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) 655161 Due to (or as a consequence of): KNOULKY Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Advance Due to (or as a consequence of): IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Year Day 4☐Pregnant at time of death 5 Other (specify)

Physician /Medical Examiner Examine Hospital or Attending Physician: The law requires that the death certificate be executed

Physician

/Medical

Examiner

Funeral

Director

ıral", or items 23a or 28a-f show Examiner must be notified at

"natural"

Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natu any injury or other traumatic event, the Medical once.

Director

Funeral

Completed by

Be

2

Pages 1 and 2 should be filed within 72 hours after death with the Maryland

Baltimore, Maryland 21215-0036

burial-transit physician and Physician/Medical Certification: To To the Hospital or Attending Physical within 24 hours after death.

To the Funeral Director: After this a completely filled in by the funeral director.

Be Completed by

Medical

Division or Vital Records, P.O. Box 68760,

9 ☐ Unknown		2CI OHKHOWH				
Part II. Other significant co	onditions o	ontributing to death but not res	ulting in the underlying	g cause given in Part I.		se contribute to the cause of death? No 3 Probably 4 Unknown
·					24a. Was an autopsy performed? 1∐ Yes 2⊠No	24b. Were autopsy findings available prior to completion of cause of death? 1 □ Yes 2 □ No
25. Was case referred to medical				26. Place of Dea	th (Check only one)	
examiner? 1 ☐ Yes 2 ☐ No		Hospital: 1 ☐ Inpatient 2 ☐	ER/Outpatient 3 1	DOA Other: 4 Nursing H	ome 5 Residence	6 □Other (Specify)
2 Accident	Pending nvestigatior		28b. Time of Injury	28c. Injury at Work? 1 ☐ Yes 2 ☐ No	28d. Describe how injury	y occurred
	Could not be determined	28e. Place of injury - At h building, etc. (Special		ory, office	28f. Location (Street and City or Town, State	d Number or Rural Route Number,)
		ysician: To the best of my kno niner: On the basis of examina and manner stated.				and manner as stated. d place, and due to the cause(s)

State Registrar

DO054566

29c. License number

29d. Date signed (Month, Day, Year) 12 109

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

9801 Georgia Annu # 1-17 Silverspring Sunistra Bhogavilli 31. Date filed (Month, Day, Year)

18 2009

29b. Signature and title of certifier

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene - State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day 28 Physician/ Month GEORGE W. OLDHAM 2010 M 2009 December Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death Memorial Hospital EASTON TAILOOT If Under 1 Year If Under 24 Hrs 6. Sex 7. Age (In yrs. last birthday) 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** 1 XM 2 🗆 F Months Hours July Day, Year) 1923 **Director** 219-12-6556 86 Maryland Usual Residence of Decedent 10a. State 10c. City, Town or Location 10d. Inside City Limits aţ Director : If item 27 is marked other than "natural", or items 23a or 28a-f sl or other traumatic event, the Medical Examiner must be notified : 1 Yes 2 No Queen Anne's MD Centreville 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Completed by Funeral 207 Belvedere Ave. 21617 U.S.A. 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-11. Marital Status 14. Race - American Indian. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Black, White, etc. 1 Never Married 2 🙀 Married X Yes 72 hours after If Yes, Give 1 Yes 2 No Specify: White Year or Dates. WWII 3 Divorced 4 Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) d Mental Hygiene. marked other than Elementary/Seconday (0-12) College (1-4 or 5+) be filed within Service Foreman Telephone Company Be Maryland 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ဂ္ George W. Oldham Pearl Woodall permit. Page 1 and 2 should be Department of Health and Mer Important: If item 27 is marke any injury or other traumatic 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Isabelle F. Oldham (wife) Belvedere Ave. Centreville, MD. 21617 Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Chesterfield Cemetery 12/31/09 Centreville, MD. 21. Sign 22. Name and Address of Facility
Galena Funeral Home of Stephen L Schaech
1118 West Cross St. Galena, MD. 21635 M00510 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between Onset and Death shock, or heart failure. List only one cause on each line. Immediate Cause (Final Physician/ disease or condition resulting in death) HYDNIC Medical Due to (or as a consequence of): Examiner Sequentially list conditions. if any, leading to immediate cause. Enter Underlying Due to for as a conseducince of Exami b Hospital or Attending Physician: The law requires that the death certificate be executed 24 hours after death.
b Funeral Director: After this certificate has been signed by the attending physician and Cause (Disease or iinjury been signed by the attending physician and should be detached for use as the burial-trans that initiated events resulting in death) Last Due to (or as a consequence of): Be Completed by Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?
1 ☐ Yes 2 ☐ No Month Year Day 4 Pregnant 9 Unknown Pregnant at time of death 5 Other (specify) 1 Yes 2 D Part_II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? CELL BLADDER 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☐ No 24a, Was an After this certificate has I Yes 25. Was case referred to medical examiner?
1 ☐ Yes 2 No completed filled in by the funeral director, 26. Place of Death (Check only one) Certificate: To 1 Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 4 Nursing Home 5 Residence 6 Other (Specify) 28a. Date of injury (Month, Day, Year) Manner of Death 28c. Injury at work? 1 ☐ Yes 2 ☐ No 28b. Time of 28d. Describe how injury occurred injury 5 Pending ☐ Accident ☐ Suicide Investigation 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Cyrtifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check To the within 2 only one) Signature and title D00538/5 2009 person who completed cause of death (Item 23a) (Type, Print) ST SENTON MD 9/2D

DHMH 17 Rev 7/2009

State Registrar

phan O. Osb		State of Maryland / Department of Certificate of Ce	f Health and Mental Hy f Doath		2000 1200
		- For State Certificate O Registrar 1. Decedent's Name (First, Middle,Last)	T Death	Reg. No 2. Date of Death	3. Time of Death
Physicia eطناحوا Exami		Stephan Oneil Osborne		Month Day December 13,	2009 0322 hrs
		4a. Facility Name (if not institution, give street and number)	4b. City, Town, or Location of Death		c. County of Death Prince George's
		8925 Loughran Rd 5 Social Security Number	Oxon Hill If Under 1 Year If Under 24Hrs.		WDD/YYYY) 9. Birthplace (State or Foreign
Funeral Director		5. 55544 55544, Names	Months Days Hours Min.	4/20/19	Country)
Director	ļ	579-04-6045 1 XM 2 F 28 Yi	3.	14/20/13	
any		10a. State 10b. County 10c. City, Town or Local	ition		10d. Inside City Limits 1 X Yes 2 No
daryland 28a-f show any 1 at once.	5	MD Prince Georges Hyattsv	ile 10f. Zip Code	10g. C	itizen of What Country?
Mary r 28a- ed at	Director	10e. Street and Number	20785		ited States
21215-0036 uld be filed within 72 hours after death with the Maryland Mental Hygener, marked other than "natural", or items 23a or 28a-f show cevent, the Medical Examiner must be notified at once.		3112 Amador Drive 11. Marital Status 12. Was Decedent Ever in U.S. 13. W	as Decedent of Hispanic Origin? (Sp	pecify Yes or No-	14. Race - American Indian, Black, White, etc.
eath w items	Funeral	1 X Never Married 2 Married Armed Forces? If	Yes, specify Cuban, Mexican, Puerto	Rican, etc.)	
after d al", or	by Fi	3 Widowed 4 Divorced If Yes, Give Year 1	Yes 2 X No specify: ent's Usual Occupation (Give kind of	work done	specify:Black b. Kind of Business/Industry
hours natur Exami	be le	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5+)	most of working life. DO NOT use ret		
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5-00 ed with tygien other	Son	17. Father's Name (First, Middle, Last)		e (First, Middle, Maid	
21215-0036 und be filed within 7 Mental Hygiene. marked other than	Be	Dudley Oneil Keitts 19a. Informant's Name/Relationship (Type, Print) 19b. Mail	FLoren ing Address (Street and Number or	a E. Osb Rural Route Number,	Orne , City or Town, State, Zip Code)
Sho sho and and ris	2	Florena E. Carter/mother 311	2 Amador Dr., H		
e, M and 2 Health item 2		20a. Method of Disposition	Oblition (Haine of Cometer)	Date 20	c. Location - City or Town, State
Baltimore, permit. Pages 1 a Department of He Important: If ite		1 X Burial 2 Cremation 3 Removal from State Cedar	Hill 12	/21/09	Suitland, MD
altir mit. I partm porta ury o		21 Someture of Funeral Service Licensee 22	. Name and Address of Facility		420 H St.NE
		23d Part Enter the disease, or complications that caused the death. Do not enter	B.K. Henry Fun	eral Hom or respiratory arrest,	shock, or heart Approximate Interval
Physiciar		Multiple Curchet Mounds	, , , ,		Between Onset and Death
x amine	1	Immediate Cause (Final disease or condition resulting in death) a. MUITIPLE GUISTION VOOTIGS Due to (or as a consequence of):			
	L	Sequentially list conditions, if any leading to immediate Due to (or as a consequence of):			
	nine	cause. Enter Underlying Cause (Disease or leiting that initiated c.		27. —	
ed ed	Examiner	events resulting in death) Last Due to (or as a consequence of):			
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Records, P.O. Box 68760, The law requires that the death certificate be incare has been signed by the attending physis	cian/Me	23b. Was decedent pregnant in the past 12 months? 1 Live birth 2 4 Pregnant at time of death 5	Fetal death 3 Ectopic preg	nancy	World Suy
Box 6 e death cer the attendi	vsic	1 Yes 2 No 9 Unknown g Unknown		Did toho	cco use contribute to the cause of death?
ires that the signed by t	hv Phv		ne underlying cause given in Part I.		2 No 3 Probably 4 Unknown
S, P quires t	Ped			24a. Was an	
Records, The law requir fificate has been s	• I ≅			_ autopsy perform	ed? death?
			26.Place of Death (Che		
Vital Rec ysician: The I his certificate I	a a	examiner? Hospital: 1 Inpatient 2 ER/Outpa	ient 3 DOA Other Nur	sg	esidence 6 🗸 Other: Scene
on of Vital tending Physician: eath. ors After this certif	F	27 Manner of Death 28a. Date of Injury 28b. Time		28d. Describe ho Subject shot	w injury occurred
ttendi death.	it it	1 Natural 5 Pending Investigation 2 Accident Pending Investigation 28e. Place of Injury - At home, farm,	3	28f. Location (Str	reet and Number or Rural Route Number, City
Division of Vital pila or Attending Physician cours after death.	ortification.	3 Suicide 6 Could not be determined (Specify) Single Family	street, ractory, office building, co.	or Town, Sta 8925 Loughran	rte) Road , Oxon Hill, MD
lospita 4 hour	ح ا د	29a, Certifier	occurred at the time, date and place, a	and due to the cause	(s) and manner as stated.
o the lithin 2	ompier die	one) 2 Medical Examiner: On the basis of examination and/or investant manner stated.	tigation, in my opinion, death occurre	ed at the time, date at	in place, and due to the education
P S F S F S	° 2	29b. Signature and title of certifier			December 13, 2009
		CRUMULA A CONTROL OF A CONTROL OF A CONTROL (Nom 22a)	1		
R 5		Zabiullah Ali, M.D. Assistant Medical Examiner 111	Penn Street, Baltimore, MD	21201	
1	Stat	e 31. Date filed (Month, Day Year) 32. Registrar's Signature 1. Aparts			
To the Hospi within 24 hou	Completely	29a. Certifier 1 Certifying Physician: To the best of my knowledge, death of one) 2 Medical Examiner: On the basis of examination and/or investant manner stated. 29b. Signature and title of certifier 30. Name and address of person who completed cause of death (Item 23a) Zabiullah Ali, M.D. Assistant Medical Examiner 111	29c. License number O.C.M.E. Penn Street, Baltimore, MD	and due to the cause ed at the time, date ar	(s) and manner as stated. nd place, and due to the cause(s) 29d. Date signed (Month, Day, Year

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1 Decedent's Name (First Middle Last) 2. Date of Death 3. Time of Death Physician/ Jerauld Thomas Oberholtzer December 2009 7:07 A^{M} Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Shady Grove Adventist Hospital Rockville Montgomery . Social Security Number If Under 1 Year If Under 24 Hrs. **Funeral** 6. Sex 7. Age (In yrs. last birthday) 8. Date of Birth 9. Birthplace (State or Foreign Days Hours April 24, 1 X M 2 D F 1935 Washington, DC 217 30 1024 Director Usual Residence of Decedent ral", or items 23a or 28a-f show Examiner must be notified at 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits 72 hours after death with the Maryland Director 1 X Yes 2 No Maryland Montgomery Montgomery Village 10e. Street and Number 10g. Citizen of What Country? Funeral 18948 Montgomery Village Avenue 20886 United States 12. Was Decedent Ever in U.S.
Armed Forces?

1 ☒ Yes 2 ☐ No 1957
If Yes, Give 1959 Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian Black, White, etc. 1 Never Married 2 Married Completed by Maryland 21215-0036 1 ☐ Yes 2 X No Specify: "natural", 3 Widowed 4 Divorced Specify: 1959 White Year or Dates traumatic event, the Medical 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) 2 should be filed within 72 l h and Mental Hygiene. 7 is marked other than "r Environmental Elementary/Seconday (0-12) College (1-4 or 5+) Technical Coordinator Protection Agency Be 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) ည Jerauld Oberholtzer English Hodges 19a. Informant's Name/Relationship (Type, Print) (Spouse) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Page 1 and 2 sh Department of Health ar Important: If item 27 is any injury or other tra Mary Frances Oberholtzer 18948 Montgomery Village Ave, Montgomery Village, MD Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State December y 17, 2009 1 Burial 2 K Cremation 3 Removal from State 4 Donation 5 Other (Specify) Metropolitan Crematory ALexandria, Virginia 22. Name and Address of Facility DeVol Funeral Home 21. Signature of Funeral Service M00689 10 E. Deer Park Drive, Gaithersburg, MD 20877 Part 1/Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, of hear) failure. List only one cause on each line. Immediate Cause (Final Onset and Death Pnysician/ Metastatic Lung Cancer disease or condition Medical resulting in death) Due to (or as a consequence of) Examiner Sequentially list conditions, Examine Due to (or as a consequence or) if any, leading to immediate cause. Enter Underlying Cause (Disease or linjury that initiated events and burial-trar Due to (or as a consequence of): resulting in death) Last Physician/Medical the Hospital or Attending Physician: The law requires that the death certificate be t phys the t Division of Vital Records, P.O. Box 68760 attending pl IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregna 5 ☐ Other (specify) in the past 12 months? Month Day Year 4 ☐ Pregnant at time of death 9 ☐ Unknown signed by the a 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 Yes 2 No 3 X Probably 4 Unknown Completed 24a. Was an 24b. Were autopsy findings available prior to completion of cause of has autopsy page death? 1 Yes 2 No Yes 2 32 No 25. Was case referred to medical Be 26. Place of Death (Check only one) 2 🔀 No Hospital Other: 1 Yes မ 1 XInpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) 28a. Date of injury (Month, Day, Year) 27, Manner of Death 28b. Time of 28c. Injury at 28d. Describe how injury occurred Certificate: To the Hospital or Attending within 24 hours after death.

To the Funeral Director: After completed filled in by the fun. 1 X Natural 5 Pending injury 1 ☐ Yes 2 ☐ No Accident
Suicide Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined City or Town, State) Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner on the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier (Check Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29b. Signature and title of certific 29d. Date signed (Month, Day, Year) 58 5+1 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

State Registrar Shahryar Davari, M.D.

31. Date filed (Month

10110 Molecular Drive, Suite 2, Rockville, MD 20854

			1 - For State Registrar	State	of Marylai	nd / Depa <i>Cei</i>	artment of I rtificate of	lealth Death	and Me		ene2 0 (9	42694
	Physici	an	Decedent's Name (First, Middle							Date of Death Month	Day	Year_	3. Time of Death
	/Medic		Mary F. P.							December		009	12:20 a ^M
	Examin	ier	4a. Facility Name (If not institution) Coffman Nursing	-	umber)		4b. City, Town, Hagers		of Death		4c. County of Washir		n
	Francis		5. Social Security Number	6. Sex	7. Age (In yrs	. last birthday)	If Under 1 Year	If Under	r 24 Hrs. 8	3. Date of Birth		9. Birthp	lace (State or Foreign
	Funeral Director		213-40-6919	1□M 2ӁF		93 Yrs.	Months Days	Hours	Min. S	(Month, Day, ept.17,		MD Coun	try)
	p ,		Usual Residence of Decedent		100.0	in. Tour and a						Ta	Od Incide City Limite
	laryla shov	7	MD Washi			ity, Town or Lo							0d. Inside City Limits 1 Yes 2 No
	the N	ect	10e. Street and Number	ngton	па	gersto	10f. Zip Code	_		10	g. Citizen of Wh	nat Coun	ntry?
	With 3a or	i D	1340 Pennsylv	ania Ave	nue		217	740			USA	ia: 000i	
	death ms 2	Jera	11. Marital Status	12. Was De	cedent Ever in U	J.S. 13.	Was Decedent of	Hispanic Or	rigin? (Spec	ify Yes or No-	14. Race		
9	after or ita	Fu	1 ☐ Never Married 2 ☐ Marri	Armed F ed 1 ☐ Yes If Yes, G	2 🔀 No		f Yes, specify Cub 1 ☐ Yes 27 No			ican, etc.)	Specify:	White,	etc.
21215-0036	filed within 72 hours after death with the Maryland Hygiene. uther than "natural", or itams 23a or 28a-f show ent, the Medical Examiner must be notified at	Completed by Funeral Director	3 X Widowed 4 □ Divorced	Year or l					•			Whi	
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<u>la</u>	uld be Venta Venta Irkad Itic ev	To B	Edward P. Fost					Co	ra Hi	11			
Maryland	permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Heelih and Mental Hygiene. Important: If item 27 is markad other than "natural", or itams 23a or 28a-1 show any injury or other traumatic event, the Medical Examiner must be notified at once.	ľ	19a. Informant's Name/Relationsh				ng Address (Stree				-	tate, Zip	Code)
	and leelth m 27 her tr		Mary Beth Truax	/Daughte		_	ox 148 C		A				
Baltimore,	ges 1 It of H If ite		20a. Method of Disposition 1 Burial 2 □ Cremation		State 200.	cemetery, crer	sition (Name of natory or other pla	1	Da		0c. Location - C		
豊	it. Pa rtmer rtant: njury		4 Donation 5 Other (Sp. 21. Inatur of Fune al Service L		Ced		n Memori			2010 Ha			MD
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on	Attending For death. ector: After by the funer	atio	1 Natural 5 ☐ Pending		nth, Day Year)	Injury		rk?]Yes 2. □	No				
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	To the Hospital or Atten within 24 hours after deat To the Funsral Director: completely filled in by the	Med	one) 29b. Signature and title of certifier	and mai	nner stated.		29c. Licen	se number		29	d. Date signed	(Month,	Day, Year)
1	F ≥ F 8		M10. 2	/ / han			h		61		12.21		
	•		30. Name and address of person v	who completed cau	se of death (Ite	m 23a) (Type.	Print)	4650) [
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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death **Physician** Jefferson Parks 14, 2009 9:20 P M December /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death Examiner Montgomery 2801 Blazer Court Silver Spring If Under 1 Year | If Under 24 Hrs. Birthplace (State or Foreign Country) 8. Date of Birth (Month, Day,
Jun 23, 7. Age (In vrs. last birthday) Funeral Social Security Number Months Days Hours 1 □ M 2 💢 F 579-26-6769 Washington, D.C. Director 1924 85 Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10a. State 10b. County 28a-f show ortant: If item 27 is marked other than "natural", or items 23a or 28a-f shov Injury or other traumatic event, the Madical Examiner must be notified at 1 ☐ Yes 2 ☑ No Director MD Silver Spring Montgomery 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? USA 20906 2801 Blazer Court Funeral 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 11. Marital Status 1 □Yes 2 No If Yes, Give Year or Dates: 1 Never Married 2 Married 1 □Yes 2X No Specify: þ Specify: Black 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Education 5+ Teacher 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be 12 should be fi. h and Mental F. Willia Viola Earles Joseph Edward Jefferson ပ္ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Pages 1 and 2.
Department of Health a 2801 Blazer Ct. Silver Spring, MD 20906 William J. Parks, Jr./husband 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Final Journey Crematory 12/17/09 Woodbine, MD 21. Signatur of Funeral Service Licenses Going Home Cremation Service P.O. Box 784 Beverly L. Heckrotte, P.A. Clarksville, MD 21029 MO1251 23a. Part 1. Enter the disease, or complishock, or heart failure. List only or s that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between Immediate Cause (Final disease or condition resulting in death) **Physician** /Medical Due to (or Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examine Due to (or as a To the Hospitai or Attending Physician: The law requires that the death certificate be executed and Due to (or as a consequence of) burial-Box 68760. attending physician for use as the buria Physician/Medical IF FEMALE: If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? 1 □Yes 2 ☑No Month Year Day 4 ☐ Pregnant at time of death 5 Other (specify) P.0. 9☐ Unknown 9 Unknown signed by the Part II. Other significant conditions conf t resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, Š 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown certificate has been s rector, page 2 should Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed2 1 ☐ Yes 2 ☑ No 1 ☐Yes 2 ☐ No director, 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Other: 4 \sum Nursing Home 2 No 1 ☐ Yes 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To this 5 Residence 6 □Other (Specify) After thi funeral 28a. Date of Injury (Month, Day, Year) 27. Ma er of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural 5 Pending within 24 hours after death.

To the Funeral Director: A completely filled in by the fu investigation 1 ☐ Yes 2 ☐ No 2 Accident ☐Could not be 3 Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determ 4 Homicide Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

State Registrar 29b. Sid

31. Date filed (Month, Day

are and title of certifier

Year

DEC 16

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29d. Date signed (Month, Day,

0

L. BIZKIMB

			State of Ma	iryland i	_	rtificate of l			Reg. No.2	009	42696
			Registrar 1. Decedent's Name (First, Middle, Last)					2. Date of Dea		Year	3. Time of Death
	Physicia /Medic		Jordan Pinkney Jr					Decemb			2:39P ^M
	Examin		4a. Facility Name (If not institution, give street and number)			4b. City, Town, or	r Location of Death		4c. Cour	nty of Death	
			Southern Maryland Hospi 5. Social Security Number 6. Sex 7. Age	tal (In yrs. last	hirthday)	Clin If Under 1 Year	ton I If Under 24 Hrs.	8. Date of Birt	Pri	nce Ge	eorges lace (State or Foreign try)
	Funeral Director		579-64-8355 1\(\overline{\text{\$\sigma}}\) M 2□F	60	Yrs.	Months Days	Hours Min.	(Month, Day	y, Year) 3 - 1949	Ooun Wash	try) DC
ъ			Usual Residence of Decedent					1000.2			0d. Inside City Limits
laryla	shov	or	10a. State 10b. County	10c. City, To						[]	1 Styles 2 □ No
the M	28a-i	Director	MD PG 10e. Street and Number	Temp	ple :	Hills 10f. Zip Code			10g. Citizen o	of What Coun	try?
h with	23a or	al Di	2101 Sayan Court			20	748		Unite	d Sta	tes
r deat	ems,	Funeral	11. Marital Status 12. Was Decedent E Armed Forces?	ver in U.S.	13. V		lispanic Origin? (Span, Mexican, Puert			Race - Americ	an Indian,
U Z IZ I 3-0030 filed within 72 hours after death with the Maryland	, or it	by Fı	1 ☐ Never Married 2 ☑ Married 1 ☑ Yes 2 ☐ N If Yes, Give 3 ☐ Widowed 4 ☐ Divorced Year or Dates:	lo		□Yes 2√ No	Specify:		Spe	cify:	1-
S hour	atural cel E		15. Decedent's Education	1	6a. Deced	ient's Usual Occup	ation		16b. Kind of	Blad Business/Ind	
6.1.3 Thin 72	e. Medi	Completed	(Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5-	+)	(Give I life. E	kind of work done on the common of the commo	during most of world)	king			
ed wil	lygien her th it, the		12	т:	rain	and Bu	s Opera 18. Mother's Nam	tor		tro	
l be fil	ed otl	Be	17. Father's Name (First, Middle, Last) Jordan Pinknev Sr				Ollie		walden Suri	iame)	
should	nd Me mark matic	은	Jordan Pinkney Sr 19a, Informant's Name/Relationship (Type, Print)		19b. Mailin	g Address (Street	and Number or Ru	Parks ral Route Numbe	er, City or Tov	wn, State, Zip	Code)
md 2	alth a 27 is er trau		Violet Pinkney/wife	i	2101	Sayan	Court	20748			
es 1 g	of He fitem roth		20a. Method of Disposition 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State	20b. Place ceme	e of Dispos etery, crem	Sayan le Hill sition (Name of natory or other place	ce)	Date	20c. Locatio	on - City or To	wn, State
. Pag	tment tant: I jury o		4 □ Donation 5 □ Other (Specify)	Ceda	r Hi	ll Ceme	tery 12	/29/09	Sui	tland	,Md.
Da Da	Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any Injury or other traumatic event, Its Medical Execting must be notified at once.		21 Signature of Funeral Service Licensee	al . !	7 22	. Name and Addre	ss of Facility HO	dges &	Edwa:	rds E	H. Md.20746
	0		23 Part 1. Enter the disease, or complications that caused	the death. [_	-		ranu,	Approximate
Ph	ysician		mock, or heart failure. List only one cause on each lin	e.			diovasc		,	ce	Interval Between Onset and Death
<i>}_/</i> [Medical		Due to (or as a	a consequen	ice of):		4101436	Viac	21304		
Ex	aminer	<u>.</u>	Sequentially list conditions, b. Ayp	er/i	1210	emic sirv					
petr	nsit	mine	School Miles of the cause. Enter Underlying Cause (Disease or injury that initiated events	a consequen	ten:	5100					
execu	in and ial-tra	Examiner	that initiated events resulting in death) Last C. Due to (or as a	consequen	ice of):	7117					
oor oo, ficate be executed	ng physician and as the burial-transit	edical	d								
ertifica	ding pl	Med	IF FEMALE:	-6							70 (37)
eath ce	attenc for us	sician/M	23b. Was decedent pregnant in the past 12 months? 1	2 Fetal de	eath 3	Ectopic pregn <i>a</i> nc Other (specify)	:y			Date of delive Month	ery D <i>a</i> y Year
j e	by the	Physic	1 ☐ Yes 2 ☐ No 9 ☐ Unknown 9 ☐ Unknown	timo or dod.	0						
s that	ned b	by Pł	Part II. Other significant conditions contributing to death but		ng in the ur	nderlying cause giv	en in Part I.	23e. Did te	obacco use c	ontribute to t	he cause of death?
v requires t	en siç	edk	prostate cancer					1 🗆 \	res 2 □ No	o 3 ☐ Prot	pably 4 Unknown
law C	as be	Completed	·					24a. Was autop	osy	prior to co	psy findings available mpletion of cause of
The T	icate l	S						1 □ Yes	rmed? 2 A No	death? 1 □ Yes	2 🗖 No
V IL	recto	o Be	25. Was case referred to medical examiner? 1 \(\text{Yes} \) 2 \(\text{No} \) No Hospital: 1 \(\text{Inpatie} \)	05/50	1 (O t t i	nt 3 DOA Oth	26. Place of Dea			Other (0	
9 A	er this		27. Manner of Death 28a. Date of Injur	ry 28	Bb. Time of Injury			ome 5 Resident			<u>y) </u>
endin O	eath.	ertification: T	2 Accident investigation	, rear	Hijary		Yes 2 □ No				
" ₽	ecto by t	ij	3 ☐ Suicide 6 ☐ Could not be determined 28e. Place of Inju	ry - At home (Specify)	e, farm, stre	eet, factory, office		28f. Location (3 City or Tox		ımber or Rura	al Route Number,
A P	= <u>=</u> £	3-									
pital or A	ours afte	O	29a. Certifier 1 □ Certifying Physician: To the best of	of my knowle	edge, death	n occurred at the ti	me, date and place	e, and due to the	cause(s) and	manner as	stated.
e Hospital or A	24 hours afte te Funeral Dir sletely filled in	O	29a. Certifier (Check only one) 1 Certifying Physician: To the best of Medical Examiner: On the basis of and manner sta	examination	edge, death n and/or in	n occurred at the ti vestigation, in my o	me, date and place opinion, death occu	e, and due to the urred at the time,	date and place	d manner as s ce, and due t	stated. o the cause(s)
To the Hospital or A	within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending completely filled in by the funeral director, page 2 should be detached for use a	Medical Cer	(Check only one) 2 Medical Examiner: On the basis of and manner states 29b. Signature and title of certifier	examination	edge, death n and/or in	vestigation, in my o	opinion, death occu se number	urred at the time,	date and place 29d. Date sign	ce, and due to	Day, Year)
To the Hospital or A	within 24 hours afte To the Funeral Dir completely filled in	O	(Check only one) 2 Medical Examiner: On the basis of and manner star. 29b. Signature and title of certifier	examination	n and/or in	vestigation, in my o	opinion, death occu se number	urred at the time,	date and place 29d. Date sign	ce, and due to	Day, Year)
To the Hospital or A	within 24 hours afte To the Funeral Dir completely filled in	O	2 Medical Examiner: On the basis of and manner star. 29b. Signature and title of certifier 30. Name and address of person who completed cause of de	eath (Item 23	n and/or in	vestigation, in my o	opinion, death occu se number	urred at the time,	date and place 29d. Date sign	ce, and due to	Day, Year)
To the Hospital or A	within 24 hours afte To the Funeral Dir. Completely filled in	Medical C	(Check only one) 2 Medical Examiner: On the basis of and manner star. 29b. Signature and title of certifier	eath (Item 23	and/or in	vestigation, in my o	opinion, death occu se number	urred at the time,	date and place 29d. Date sign	ce, and due to	o the cause(s)

Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death DECEMBER 17 2009 **Physician** RUTH PEETE 5:10 P M /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner HOLY CROSS HOSPITAL SILVER SPRING MONTGOMERY If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) JAN 30 1945 9. Birthplace (State or Foreign 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) **Funeral** Min 1 □ M 2 😿 F Months Days Hours 577-62-2577 WASHINGTON, DC Director Usual Residence of Decedent 10d. Inside City Limits 10a. State 10c. City, Town or Location 28a-f show If item 27 is marked other than "natural", or items 23a or 28a-f sho or other traumatic event, it with the marker must be notified at Yes 2 No Director MD PRINCE GEORGE'S LANHAM 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code Funeral 1515 3RD STREET 20706 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 11. Marital Status permit. Pages 1 and 2 should be filed within 72 hours after 1 Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or iter any injury or other traumatic event, the Worldon Examiner once. 1 □Yes 2 No If Yes, Give No 1 Never Married 2 Married BLACK 1 ☐ Yes 2 ☐ No Specify: Completed by 3 Widowed 4 □ Divorced Year or Dates: 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life, DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) OFFICE MANAGER PRIVATE 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be WILLIAM N. DEAN SR. **EDNA** I. TRUEHEART ပ္ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) DENISE FIELDS/DAUGHTER 1515 3RD STREET LANHAM, MARYLAND 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) LINCOLN CEMETERY SUITLAND, MARYLAND 12/23/09 22. Name and Address of Facility J. B. JENKINS FUNERAL HOME 21. Signature of Funeral Service Licenses . D.A 7474 LANDOVER ROAD LANDOVER, MARYLAND Approximate Interval Between Onset and Death 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final **Physician** DIABETES MELLITUS resulting in death) /Medical Due to (or as a consequence of) CHRONIC OBSTRUCTIVE PULMONARY DISEASE Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examine To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and END STATE RENAL DISEASE Due to (or as a consequence of): Be Completed by Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant 1 Live birth 2 Fetal death 3 🗆 Ectopic pregnancy in the past 12 months? 1 □Yes 2 □No Year Month Day 4 ☐ Pregnant at time of death 5 ☐ Other (specify) 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? autopsy performed? 1 ☐ Yes 2 🗖 No 2X□No 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 X Inpatient 1 Yes 2 No Certification: To 2 ER/Outpatient 3 DOA 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of Injury 28d. Describe how injury occurred 28c. Injury at Work? 5 ☐ Pending investigation 1 Natural 1 ☐Yes 2 ☐ No 2 Accident 6 ☐ Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical (Check only 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) 29c. License number D32332 **DECEMBER 20, 2009** 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) SURESH K: GUPTA M.D. 9801 GEORGIA AVENUE SUITE 220 SILVER SPRING, MARYLAND 20902 31. Date filed (Month, Day, State DEC 2 3 2009 Registrar

ORIGINAL

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 42698 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ 12712/2009 ADWINNA E. POLLACK 0200 Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City. Town, or Location of Death 4c. County of Death Rockville Montgomery Shady Grove Adventist Hospital Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. Social Security Number 6. Sex 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** 1 M 2 X F Hours Min. 04/02/1924 Country) Jamaica Director 117-48-4403 Usual Residence of Decedent shov 10a. State 10b. County 10d. Inside City Limits ral", or items 23a or 28a-f sho Examiner must be notified at 10c. City, Town or Location Director 1 Yes 2 No MD Montgomery Gaithersburg 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 19923 Buhrstone Drive 20886 12. Was Decedent Ever in U.S. Armed Forces?
1 ☐ Yes 2 No If Yes, Give Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, ģ 1 Never Married 2 Married 72 hours after Maryland 21215-0036 1 ☐ Yes 2 XNo Specify: Specify: Black "natural" Completed 3 ♥ Widowed 4 □ Divorced Year or Dates the Medical 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) permit. Page 1 and 2 should be filed within 73 Department of Health and Mental Hygiene. Important: If item 27 is marked other than any injury or other traumatic event, the Me Elementary/Seconday (0-12) College (1-4 or 5+) Certified Nurse Assistant Nursing 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Gustavus C. Gordon Sarah Brown 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19923 Buhrstone Dr, Gaithersburg, MD 20886 Janice A. DuFour - daughter Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of cometery, crematory or other place) 20c. Location - City or Town, State 1 🔀 Bunjal 2 🗌 Cremation 3 🔲 Removal 1/9/2010 4 Departion 5 Other (Specify) Dóvedot Cemetery Jamaica, W. Indes 21. Sign of Funeral Service 22. Name and Address of Facility Snowden Funeral Home 246 N. Washington St, Rockville, MD 20850 23a. Part 1. Enter the disease, or co shock, or heart failure. List on pplications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest one cause on each line. Approximate Interval Between Immediate Cause (Final Onset and Death Enysician/ Acute respiratory failure disease or condition Medical Examiner resulting in death) Due to (or as a consequence of) Septic shock Sequentially list conditions, Examine Duri to (or as a none-quence of): if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury that initiated events Cutaneous T-cell leukemia that the death certificate be executed attending physician and for use as the burial-tran Due to (or as a consequence of) resulting in death) Last Physician/Medical Gram negative sepsis IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) in the past 12 months?

1 Yes 2 X No Month Year Pregnant at time of death 9 Unknown P.O. by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? signed I ģ or Attending Physician: The law requires Clostridium difficile colitis Records, 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4X Unknown Completed 24b. Were autopsy findings available prior to completion of cause of Congestive heart failure 24a. Was an has autopsy death? performed? Yes 2 4N Acute pulmonary embolism 1 Yes 2 No Division of Vital 25. Was case referred to medical Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify 1 ☐ Yes 2 X No 1 Npatient 2 ER/Outpatient 3 DOA မ 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred 1X Natural 5 \square Pending 1 Yes 2 No within 24 hours after death

To the Funeral Director: A
completed filled in by the f Accident Investigation Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Hospital Medical

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DHMH 17 Rev 7/2009

State

Registrar

29a. Certifier

(Check

only one)

29b. Signature and title of certifier

V. Ganti, MD

31. Date filed (Month, Day, Year)

DEC 18 2009

- auti

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Registrar's Sier

19529 Doctor Dr. Germantown, MD 20874

1 💹 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29c. License number

D41162 MD

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated

29d. Date signed (Month, Day, Year)

12/12/2009

Medical Examiner 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of It Berlin Funeral 5. Social Sectirity Number 6. Sex 10 M 2□ F 7. Age (In yrs. last birthday) 11 Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 12 M 2□ F 13 M 2□ F 14 D M 2□ F 15 Months Days Hours Min. (Month, Day, Year)	
Physician /Medical Examiner 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Examiner 4c. County of Examiner 4d. Social Sectifity Number 5. Social Sectifity Number 6. Sex 100 Month Day Year 100 Month Day Year 4c. County of Examiner 4c. County of Examiner 4d. County	Death Star Birthplace (State or Foreign Country) Start Malc
Medical Examiner 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of E At an	Death Ster Birthplace (State or Foreign Country) 10d. Inside City Limits
Funeral Director Social Septirity Number 6. Sex 12 Months Days Hours Min. (Month, Day, Year) Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location	Birthplace (State or Foreign Country) Sixual Male 10d. Inside City Limits
Funeral Director 5. Social Sectifity Number 6. Sex 12 M 2 F 7. Age (In yrs. last birthday) 5. Social Sectifity Number 6. Sex 12 M 2 F 7. Age (In yrs. last birthday) 6. Sex 13 Yrs. 10 Loc. City, Town or Location 10 Loc. City, Town or Location 10 Loc. City, Town or Location	Birthplace (State or Foreign Country) 3 Lead male 10d. Inside City Limits
Director Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location	10d. Inside City Limits
Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location	10d. Inside City Limits
10a. State 10b. County 10c. City, Town or Location 10a. State 10b. County 10c. City, Town or Location 10b. Street and Number 10f. Zip Code 10g. Citizen of What County 1	
10e. Street and Number 10f. Zip Code 10g. Citizen of What County Count	1 ☑ Yes 2 ☐ No
10e. Street and Number 10f. Zip Code 10g. Citizen of Wha	1
21842 Gueta	
= A = P 100 V W. Dale were	mala
11. Marital Status 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race -/ Black, V	American Indian, White, etc.
Armed Forces? 1 Never Married 2 Married 1 Tyes 2 No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Black, V 1 Never Married 2 Married 1 Tyes, Give 1 Married 1 Mayes 2 No If Yes, Give 1 Mayes 2 No Specify: Spec	,
Specify: Specify:	Guatemolteca
15. Decedent's Education (Specify only highest grade completed) (Specify only highest grade completed) (Ife. DO NOT use retired) (Ife. DO NOT use retired)	ess/industry
Elementary/Secondary (0-12) College (1-4or 5+) life. DO NOT use retired) Labor Con S.4	Worker
17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname)	
17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname)	mesin
17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City) or Town, Sta	ate, Zip Code)
	יי אברים. יי
20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City Cemetery, crematory or other place) 21. Signature, I Elimi Sendor to see	y or Town, State
20a. Method of Disposition 20a. Method of Disposition 20b. Place of Disposition (Name of Disposition (Name of Disposition) 20c. Location - City Commentary or other place)	
4 Donation 5 Other (Specify) 21. Signature, I Elimin Service to see	Tsabella Street
m & Bennix Smith Funeral Home Salis	starry MO 21701
23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock of heart failure. List only one cause on each line.	Approximate Interval Between
Physician Immediate Cause (Final disease or condition	Onset and Death
Medical resulting in death) Due to (or 's a consequence of):	
Examiner Sequentially list conditions. b. Gastrointestinal Bleed	
Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Due to (or as a consequence of):	
Cause (Disease or injury that initiated events resulting in death) Last C. Due to (or as a consequence of):	
fifficate be trifficate be physicia as the bun hedical	
	of delivery
Sprong of the proof of the proo	
O o o o o o o o o o o o o o o o o o o o	
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.	te to the cause of death?
7 D ain g a	☐ Probably 4 ☐ Unknown
1 Yes 2 No 3 24a. Was an autopsy performed deal autopsy perfo	re autopsy findings available ir to completion of cause of
24a. Was an autopsy prior death of the control of t	th? Yes 2 No
Tetro 2 DNo 1 D S S Was case referred to medical examiner? 25. Was case referred to medical examiner? Hospital: A S DNo 2 DNo 1 D S DN	
25. Was case referred to medical examiner? 1 Nes 2 No	(Specify)
28a. Date of Injury 28b. Time of Injury at Work?	
To be the control of	
28a. Date of Injury at Work? 1 Accident 3 Suicide 4 Homicide 28b. Place of Injury - At home, farm, street, factory, office 28b. Location (Street and Number of Death 1 Accident 3 Suicide 4 Homicide 4 Homicide 28b. Place of Injury - At home, farm, street, factory, office 28b. Location (Street and Number of Death 1 Homicide 28b. Time of Injury at Work? 1 Yes 2 No 28b. Time of Injury at Work? 1 Yes 2 No 28c. Injury at Work? 1 Yes 2 No 28b. Location (Street and Number of Death 1 Homicide 28b. Time of Injury at Work? 28c. Injury at Work? 1 Yes 2 No 28b. Location (Street and Number of Death 1 Homicide 28b. Time of Injury at Work? 28c. Injury at Work? 1 Yes 2 No 28c. Injury at Work?	or Rural Route Number,
1 Yes 2 No 3 2 2 No 3 2 2 No 3 2 2 2 No 3 2 2 2 2 2 2 2 2 2	or on stated
The part of the pa	due to the cause(s)
Jason Symbol H64428 12/26/	2009
30. Name/and address of person/who completed cause of death (Item 23a) (Type, Print)	Dr.Ve
State Registrar Juson Szymala NO Atlantic teneral Hospital Berlin, MD 218 32. Fégistrar's Signature Ann 5 2010 JAN 0 5 2010 Atlantic teneral Hospital Berlin, MD 218) I (
Registrar JAN 0 5 2010 Sinua B. Aparke	

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Day 24 2009 **Physician** ALICE B. RICE 4:33 PM December /Medical 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Death Examiner Harford Memorial Hospital Havre de Grace Harford If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 9. Birthplace (State or Foreign Country) Pennsylvania Birthplace (State or Foreign Country) 5. Social Security Number 7. Age (In yrs. last birthday) 6. Sex **Funeral** Months Days Hours Min. 1 □ M 2 🕅 F 170-24-1750 108 Director Usual Residence of Decedent death with the Maryland 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits If item 27 is marked other than "natural", or Items 23a or 28a-f show or other traumatic event, the Medical Examiner must be notified at MD Harford Darlington 1 □ Yes XXNo Director 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number 3711 Berkley Road 21034 USA Funeral permit. Pages 1 and 2 should be filed within 72 hours after dea Department of Health and Mental Hygiene. Important: If frem 27 is marked other than "natural" ~ any lijury or other traumatic event. 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☐ No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. Black, White, etc. 1 Never Married 2 Married 1 ☐ Yes 2 🔀 No Specify: Be Completed by Black 3 Widowed 4 ☐ Divorced 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Homemaker Own Home Unknown 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) William Dorsey Unknown 2 19a, Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Larry Rice/Grandson 3711 Berkley Road, Darlington, MD 21034 20c. Location - City or Town, State 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State Trinity AME Cem. 1/2/2010 4 Donation 5 Dother (Specify) Delta, PA 22. Name and Address of Facility 21. Signature of Funeral Service Licens Harkins Funeral Home, Inc., Delta, PA17314 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Physician /Medical Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner The law requires that the death certificate be executed 100 attending physician and Due to (or as a consequence 68760. Physician/Medical IF FEMALE: Box 23c. If yes, outcome of pregnancy
1 Live birth 2 Fetal death
4 Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 C Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Year 5 Other (specify) Ö σ, Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? \$ Records, 1 ☐ Yes 2 ☐ No 3 ☐ Frobably 4 ☐ Unknown Be Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has autopsy performed? certificate Vital 1 ☐ Yes 2 ☐ No ospital or Attending Physician: hours after death. 25. Was case referred to medical 26. Place of Death (Check only one) examiner? 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 1 No Certification: To Division of this 28a. Date of Injury (Month, Day, Year) 27. Ment of Death 28b. Time of After t 28d. Describe how injury occurred 28c. Injury at Work? 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident Director: 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) determined 4 Homicide within 24 hours a

To the Funeral I

completely filled 29a, Certifie 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29b. Signature and title of certifier 29c. License number 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death Decedent's Name (First, Middle, Last) Pay 26 **Physician** ecember /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner **Baltimore City** The Johns Hopkins Hospital 6. Sex 1 X M 2 F | If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth (Month, Day, Year 11-15-1967 Birthplace (State or Foreign Country) Social Security Number 7. Age (In yrs. last birthday) **Funeral** 366-80-3877 42 Detroit MI Director Usual Residence of Decedent Pages 1 and 2 should be filed within 72 hours after death with the Maryland 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits 28a-f show 1 ¥ Yes 2 □ No Director the Medical Examiner must be notified MI Wavne Detroit 10e. Street and Number 10f. Zip-Code 10g. Citizen of What Country? 6 2660 Webb St. items 23a 48206 USA Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 Yes 2 No Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 11. Marital Status 1 Never Married 2 Married Baltimore, Maryland 21215-0036 ò 1 ☐ Yes 2 No Black If Yes, Give Year or Dates: Specify þ 3 ☐ Widowed 4 ☐ Divorced natural", Completed 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation 15. Decedent's Education (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5+) and Mental Hygiene. Mechanical Figureer Manufacturing 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Leon Reynolds Josephine Denson မ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) Department of Health ar Important; If item 27 is any injury or other trau once. Catrina L. Reynolds Wife 2660 Webb St., Detroit MI 48206 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 Burial 2 ☐ Cremation 3 X Removal from State St. Paul (Wolf's) Cemetery 01-02-2010 4 ☐ Donation 5 ☐ Other (Specify) York, Pennsylvania 22. Name and Address of Facility J.J. Hartenstein Mortuary, Inc. 21. Signature of Funeral Service Licenses Weell Second St., New Freedom, PA 17349 24 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** 1101 disease or condition resulting in death) /Medical **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examine Hospital or Attending Physiclan: The law requires that the death certificate be executed COMO physician and Due to (or as a consequence of) Division of Vital Records, P.O. Box 68760, Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant Live birth 2 Fetal death 3 Ectopic pregnancy in the past 12 months? 4 Pregnant at time of death 9 Unknown Month 5 Other (specify) 2 □ No 9 Unknown þ Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 Tyes 2 No 3 Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 1 ☐ Yes 2 ☐ No 24a. Was an autopsy performed 1 Yes 2 No certificate 25. Was case referred to medical 26. Place of Death (Check only one) Be examiner Other: 4 \square Nursing Home 5 \square Residence 2 No 1 Inpatient 1 Tes 2 ER/Outpatient 3 DOA 6 Other (Specify) မ 28a. Date of Injury (Month, Day Year) 27. Manner of Death 1 Natural 28b. Time of 28d. Describe how injury occurred 28c. Injury at Work? Certification: 5 Pending investigation eral Director; After filled in by the fune 1 Yes 2 No 2 Accident death. 3 Suicide Could not be 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide after City or Town, State) within 24 hours a To the Funeral C completely filled Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical (check only 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

State Registrar

31. Date filed (Month, Day, Year)

29b. Signature and title of certifier

32. Registrar's Signature

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

16,

DHMH 17 Rev 1/2001

29c. License number

29d. Date signed (Month, Day, Year)

600 North Wolfe St, Baltimore, MD, 21287

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death Month **Physician** Rudy W. Ross 19 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Hospital Bei Harfor pper Chesapeake If Under 24 Hrs. 9. Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) If Under 1 Year 8. Date of Birth (Month, Day, Year) 9 / 24 / 1960 **Funeral** Months Days 1√M 2□F Hours Min. 217-82-8136 49 Maryland Director Usual Residence of Decedent 10a. State 10b. County 10c. City. Town or Location 10d. Inside City Limits show item 27 is marked other than "natural", or items 23a or 28a-f show other traumatic event, the Modical Examinar must be notified at Director 1 ☐ Yes XIXNo Forest Hill Harford 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 21050 USA 2000 Highfield Court Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 Never Married 2 Married 1 □Yes 2 No Specify: Specify: White <u></u> 3 Widowed 4 Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) s 1 and 2 should be filed within if Health and Mental Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) Electrician Aquarium 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be June R. Dick Roy Elmo Ross မ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 2000 Highfield Court, Forest Hill, MD 21050 Amy G. Ross/Wife 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Date permit. Pages 1
Department of H
Important: If ite
any injury or ot
once. 1 XBurial 2 ☐ Cremation 3 ☐ Removal from State Darlington Cem. 12/22/09 Darlington, MD 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Juneral Service Livins 22. Name and Address of Facility C. Koberta Harkins Funeral Home, Inc. 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) ASCVI **Physician** /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying cause. Unescaled injury that initiated events resulting in death) Last Examiner Due to (or as a consequence of): Due to (or as a consequence of): attending physician for use as the buria Physician/Medical IF FEMALE 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) in the past 12 months? 1 ☐ Yes 2 ☐ No Month Year 4 Pregnant at time of death 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Records, Be Completed by 1 Yes 2 No 3 Probably 4 Unknown funeral director, page 2 should 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed Hospital or Attending Physician: The 1 ☐ Yes 2 ☐ No 1 □Yes 2 🗷 No 25. Was case referred to medical 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Medical Certification: To 1 Yes 2 □ No 1 ☐ Inpatient 2 ☑ ER/Outpatient 3 ☐ DOA 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 5 Pending investigation 1 Natural within 24 hours after death.

To the Funeral Director: 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 🗌 Homicide 18 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier completely (Check only one) 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifier DO066035

Registrar

DHMH 17 Rev 1/2001

State

oo upper Chesapeake Dr. Be | Air, Mp 21014

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

chalke

32. Registrar's Signature

Jeremi

31. Date filed (Month, Day, Year)

JAN 0 7 2010

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 42703 - State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Physician/ December Anthony Rodenhauser 2009 1020 John Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death Eastor Memoria lalbot If Under 1 Year Social Security Number 6. Sex. 1 ♣ M 2 ☐ F 7. Age (In yrs. last birthday) If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** Min. Months Hours 0471771936 Washington, DC Director 220-32-5769 73 Usual Residence of Decedent Show 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits death with the Maryland Examiner must be notified at Director 1 Xyes 2 □ No · 28a-f Caroline Denton Maryland 10e. Street and Number 10f. Zip Code 5 10g. Citizen of What Country? Funeral 23a 21629 USA 8855 Dorothy Lane or items 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S 11. Marital Status 14. Race - American Indian. Armed Forces?

1 X Yes 2
If Yes, Give Black, White, et 1 Never Married 2 Married Completed by 2 No 2/1954 Page 1 and 2 should be filed within 72 hours after White 1 Yes 2 No Specify: Koden house Baltimore, Maryland 21215-0036 3 🗌 Widowed 4 🗌 Divorced Year or Dates. 11/1957 or other traumatic event, the Medical 15. Decedent's Education 16a, Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) marked other than Elementary/Seconday (0-12) College (1-4 or 5+) Mental Hygiene. General Manager Self Employed Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) မ Rodenhauser Frances Fagnano Irvin R. Health and N 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 8855 Dorothy Lane Denton, MD 21629 S Gladys Rodenhauser (Wife) 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State December ō Important: If it any injury or o 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State Mount Oak Cemetery 30, 2009 Mitchellville, MD 4 ☐ Donation 5 ☐ Other (Specify) 21. Signatu Funeral Service Licensee Rendon/Hale Funeral Home 22. Name and Address of Facility 9013 Annapolis Rd. Lanham, Md. 23a. Part 1. Enter the disease or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between Onset and Death hock, or heart failure. List only one cause on each line. Immediate Cause (Final Physician/ disease or condition resulting in death) Medical bue to (or as a consequence of): Examiner Esquantially not conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or linjury Examine or Attending Physician: The law requires that the death certificate be executed MYO CAV 10 signed by the attending physician and defacted for use as the burial-tranthat initiated events Due to (or as a consequence of) resulting in death) Last Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy

1 Live Birth 2 Fetal death
4 Pregnant at time of death
9 Unknown 23b. Was decedent pregnant 23d. Date of delivery in the past 12 months?

1 Yes 2 No 3 Ectopic pregnancy 5 Other (specify) g Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 🗆 Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown director, page 2 should After this certificate has been 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performe 1 ☐ Yes 2 ☐ No 25. Was case referred to medical Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 24 No 1/2 Inpatient 2 ER/Outpatient 3 DOA ٩ 1 Yes completed filled in by the funeral 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred 1 Natural work? 1 ☐ Yes 2 ☐ No 5 Pending 2 Accident
3 Suicide Investigation 24 hours after deat Funeral Director: 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Hospital Medical 29a. Certifier 1 🔂 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check within 2 To the I 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) 200 30. Name and address of person who completed cause of c ath (Item 23a) (Type, Print) Easton, wo 2160 State

Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

1- For AMEND#23b+29aperMD, 12/18/09, BM DAMPRICATE of Death Registrar 1. Decedent's Name (First, Middle, Last) 2. Date of Death December 10, 2009 Physician Gordon Francis Ritchie /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Bethesda Montgomery Carriage Hill Nursing Home 8. Date of Birth (Month, Day Yes If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** Year) 1913 1 M 2 □ F Months Days Hours 96 144-07-3204 Director Usual Residence of Decedent t0a. State 10b. County 10c. City, Town or Location 28a-f show permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryla. Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Extrainact must be 1 citified at Bethesda Montgomery MDDirector 10f. Zip Code 20814 10e. Street and Number 5215 Cedar Lane 10g. Citizen of What Country? United States Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1

Yes 2

No Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 □Yes 2 No If Yes, Give WW II Specify: Completed by 3 □Widowed 4 □ Divorced 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) College (1-4or 5+) Elementary/Secondary (0-12) Machinery Salesman 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Mary Coffee Alexander Patrick Ritchie 19a. Informant's Name/Relationship (Type. Print) 19b. Malling Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1117 Marine Way, North Palm Beach, FL 33408 Mary Ritchie Poncy/Niece 200. Place of Disposition (Name of Cempters, Grematory On Disposition (Red) (Name of Cempters) (Name of Cemp 20c. Location - City or Town, State 20a. Method of Disposition Dec. Date 0 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State Washington, D.C. 2009 4 Monation 5 ☐ Other (Specify) 22. Name and Address of Facility Columbia Mortuary Services, P.A. 21. Signature of Funeral Service License 9013 Annapolis Road, Lanham, MD 20706 685 Kutaren 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) **Physician** SHAF /Medical Due to (or as a or sequence of) Examiner zbilit Sequentially list conditions, if any, leading to immediate cause. Emer underlying Cause (Disease or injury that initiated events resulting in death) Last Examine Due to (or as a consequence of): law requires that the death certificate be executed 014 and Due to (or as a consequ burial physician as the burial Box 68760 Physician/Medical attending p for use as as IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Pregnant at time of death 5 Other (specify) 1 ☐ Yes 😜 o been signed by the should be detached 9 Unknown 9 Unknown σ. 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. of Vital Records, þ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has le 2 s autopsy The page After this certificate funeral director, pag 2 No 1 □Yes Hospital or Attending Physician; 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To 28a. Date of Injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? Division 1 Natural 2 Accident 5 Pending death. Investigation 1 ☐ Yes 2 ☐ No illed in by the f 6 ☐ Could not be 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) determined 4 Homicide after To the Hospital or within 24 hours a To the Funeral D 29a. Certifier 15 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one)

28d. Describe how injury occurred 28f. Location (Street and Number or Rural Route Number, City or Town, State)

Month

Day

1 ☐ Yes 2 ☐ No

Year

6:15 А. м

Birthplace (State or Foreign Country)

10d. Inside City Limits

1X Yes 2 □ No

New Jersey

White

title of certifier

29d. Date signed (Month, Day, Year)

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

8218 Wisconsin Ave-Suite 305; Bethesda, MD Susan J. Miller, M.D.

State Registrar 29b. Signature ar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

Certificate of Death Reg. No. 2009 State Registrar 1. Decedent's Name (First, Middle, Last) 2. Date of Death DECEMBER 12, 2009 **Physician** 10:30P. M ELINOR MAE RIMAR /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner VILLA ROSA NURSING HOME Mitchellville Prince George's 7. Age (In yrs. last birthday) 85 yrs. 5. Social Security Number 577–26–5634 If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) July9,1924 9. Birthplace (State or Foreign **Funeral** Days Min. Months Hours 1 □ M 2√2 F Washington, DC Director Usual Residence of Decedent 10b. County 10c. City, Town or Location 10d. Inside City Limits permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Everniner must be notified at Prince George's Greenbelt 1 XYes 2 ☐ No Director Maryland 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 35A Ridge Road 20770 United States Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Black, White, etc. 1 Never Married 2 Married White Baltimore, Maryland 21215-0036 1 □Yes 2 No Specify: Specify ģ 3X Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary-(0-12) College (1-4or 5+) Administrator NSA 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Rosa Belle Follin Oscar Henry Souder ပ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 13328 Fitzwater Drive Nokesville, VA 20181 19a. Informant's Name/Relationship (Type. Print) Joseph W. Rimar -son 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20a. Method of Disposition 1 Burial 2 Cremation 3 Removal from State Metropolitan Crematory 12/15/2009 Alexandria, Virginia 4 ☐ Donation 5 ☐ Other (Specify) Donald V. Borgwardt Funeral Home, PA 21. Signature of Funeral Service Licensee Wonald 4400 Powder Mill Road Beltsville, Maryland 20705 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death MONTHS Immediate Cause (Final disease or condition resulting in death) T-cell Lymphoma **Physician** /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examine certificate be executed sician and burial-tran Due to (or as a consequence of): P.O. Box 68760, attending physician for use as the buria Physician/Medical 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant Hospital or Attending Physician: The law requires that the death 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ Xo Month Day Year 5 ☐ Other (specify) the 9 Unknown 9 Unknown þ vare nas been signed page 2 should be dete Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, ģ End stage renal disease 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ※ Unknown Completed 24a. Was an 24b. Were autopsy findings available prior to completion of cause of death? autopsy performed After this certificate 1 ☐ Yes 2 XNo 2X No 1 Yes 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: Other: 4 X Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 ☐ No Certification: To 1 Inpatient 2 ER/Outpatient 3 DOA 27. Manner of Death 28b. Time of Injury 28a. Date of Injury (Month, Day, Year) 28c. Injury at Work? 28d. Describe how injury occurred 12 Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No 24 hours after death. 2 Accident filled in by the 3 Suicide 6 ☐ Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

| Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical (Check only one) 2 Medical and manner stated. within 2 To the I

State

10

29b. Signature and title of certifie

31. Date filed (Month, Day, Year)

Registrar DHMH 17 Rev 1/2001

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)
Richard Feldman, M.D. 8116 Good Luck Road, #300 Lanham, Maryland 20706

3. Registrar's Signature

29c. License number

D32261

29d. Date signed (Month, Day, Year)

December 15, 2009

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ December 7:20 pm 2009 Epolane Raphael Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Takoma Park Montgomery Sligo Nursing Home 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** 1 □ M 2 🕱 F Months Days Hours Min. Mau 10, 1927 Director 213-19-4080 82 Haiti Usual Residence of Decedent 10a. State 10b. County 10d. Inside City Limits ral", or items 23a or 28a-f sho Examiner must be notified at 10c. City, Town or Location within 72 hours after death with the Maryland Director 1 Yes 2 X No Hyattsville Maryland Prince George's 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 831 Ray Road 20783 Haiti 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☒ No If Yes, Give Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Black, White, etc Completed by 1 Never Married 2 Married 1 ☐ Yes 2 X No Specify. 3 X Widowed 4 Divorced Black Year or Dates and Mental Hygiene.
is marked other than "naturaumatic event, the Medical. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life, DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) Sales Entreprenuer Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ည Nesilia Toussaint Falve Nicolas 19a. Informant's Name/Relationship (Type, Print) 19b. Malling Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Venise Raphael Constant-Daughter Hyattsville. 831 Ray Road. Maryland 20783 or other 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State Department of h Important: If ite any injury or ot Page 1 1 🗓 Burial 2 🗆 Cremation 3 🗀 Removal from State 4 Donation 5 Other (Specify) 12/19/2009 Heaven Cem. Silver Spring. 22. Name and Address of Facility Hines-Rinaldi Funeral Home, 21. Signature of Funeral Service Licen MO# 1070 <u>1800 New Hampshire Ave., Silver Spring,</u> 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final theroscleroic Physician/ disease or condition Medical resulting in death) Due to (or as a consequence of): **Examiner** Sequentially list conditions, Due to (or as a consequence of): if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Exam and that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical Hospital or Attending Physician: The law requires that the death certificate be use as IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ____ in the past 12 months?
1 Yes 2 X No 1 Yes 2 2 9 Unknown g Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 Yes 2 X No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has performed? Yes 2 X No 2 No 1 Yes To the Funeral Director: After this certific completed filled in by the funeral director, 25. Was case referred to medical 26. Place of Death (Check only one) Be examiner? Other: 4 🗓 Nursing Home 5 🗆 Residence 6 🗀 Other (Specify) Hospital 1 Yes 2 X No မ 1 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at Certificate: 28d. Describe how injury occurred 1 X Natural 2 Accident 5 Pending 1 🗌 Yes 2 No Investigation Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined 24 hours : Funeral I Medical 29a. Certifier 1 🕱 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 🛄 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. To the within 2 To the F Certifying Nurse Practioner. To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certifier D0060100 December 14, 2009 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

State Registrar Tahmina K. Ahmed.

31. Date filed (Month, Day, Year)

NFC

M.D.,

DHMH 17 Rev 7/2009

Baltimore, Maryland 21215-0036

Box 68760

P.0.

Division of Vital

831 University Blvd., East,

#27. Silver Spring. MD 20903

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 3. Time of Death Month Day Year 455 PM M 2009 Romanow December 14,

Physician /Medical Examiner

Funeral Director

with the Maryland

filed within 72 hours after

Maryland 21215-0036

Baltimore,

Pages 1 permit. Pages
Department of
Important: If it
any injury or o

ed other than "natural", or items 23a or 28a-f show event, the Medical Examiner must be notified at jes 1 and 2 should be fil t of Health and Mental H If item 27 is marked oth or other traumatic even

Physician , /Medical **Examiner**

Hospital or Attending Physician: The law requires that the death certificate be executed the hours after death. and burial-trai aftending physician as nse ę the signed | has this certificate after death Director:

Division of Vital Records, P.O. Box 68760,

1. Decedent's Name (First, Middle, Last) Sylvia 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Holy Cross Hospital Silver Spring Montgomery Birthplace (State or Foreign Country) If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 7. Age (In vrs. last birthday 8. Date of Birth (Month, Day, Year) Days Hours 1 □ M 2 🕅 F 082-12-0018 March 9, 1918 Usual Residence of Decedent 10d. Inside Cify Limits 10a. State 10b. County 10c. City, Town or Location MD Director Rockville 1 XYes 2 No Montgomery 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 1213 Treasure Oak Court 20852 United States Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 14. Race - American Indian, 11. Marital Status Black, White, etc 1 ∐Yes 2XI If Yes, Give Year or Dates: 1 ☐ Never Married 2 ☐ Married 2**X** No 1 ☐ Yes 2 ☐ No Specify: ģ Specify: White 3 Widowed 4 □ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) <u>Budget Analyst</u> US Government 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Nathan Cohen Tessie Pataki ဥ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Stuart Romanow - son 1213 Treasure Oak Court Rockville MD 20852 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Judean Mem. Gardens 12/18/2009 Olney, MD 22. Name and Address of Facility
Danzansky-Goldberg Memorial Chapels 1705
1170 Rockvillle Pike Rockville MD 20852 21. Signature of Funeral Se M01163 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or hear failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Pneumonia 3 days disease or condition resulting in death) Due to (or as a consequence of): Metastatic Lung Cancer months Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examine Due to (or as a consequence of): Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 🗆 Ectopic pregnancy in the past 12 months?
1 Yes 2 X Month Day Year 5 Other (specify) 9 I Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 ☐ Yes 2 No 3 ☐ Probably 4 ☐ Unknown Advanced Dementia, Dehydration, Cancer of Breast Completed Failure to Thrive 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? Yes 2 1 No 1 ☐ Yes 2 No 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Tes 2 No 1 XInpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical (Check only one) and manner stated. 29b. Signatuh and title of certifier 29d. Date signed (Month, Day, Year) 29c. License number D53367 December 14, 2009 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)
Shyamsundar Rajan MD 9801 Georgia Avenue #117 Silver Spring MD 20902

State Registrar

31. Date filed (Month, Day, Year)

18

within 24 hours a To the Funeral L

completely

2. Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death Reg. No. 2 2. Date of Death 1. Decedent's Name (First, Middle, Last) Month 5:30 P M 2009 Dec 18, **Physician** Rennie David 4c. County of Death /Medical 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) Examiner Prince George's Temple Hills 6709 Berkshire Drive, Birthplace (State or Foreign Country) Date of Birth (Month, Day, Year)
June 29, If Under 1 Year | If Under 24 Hrs. 7. Age (In yrs. last birthday) 5. Social Security Number 6. Sex Hours Months Days 1918 Nebraska **Funeral** M 2 - F Yrs Director 545 18 4533 Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location filed within 72 hours after death with the Maryland 10b. County 10a State item 27 is marked other than "natural", or items 23a or 28a-f show other traumatic event, the "Neutral Examiner must be notified at 1 ☐Yes 2 No Temple Hills Prince George's MD Funeral Director 10g. Citizen of What Country? 10f. Zip Code 10e Street and Number United States 20748 6709 Berkshire Drive 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 12. Was Decedent Ever in U.S.
Armed Forces?
1 MYes 2 □ No 19
If Yes, Give 1 0 1942 1 ☐ Never Married 2 Married Specify: White 1 ☐ Yes 2 ☐ No Specify: Baltimore, Maryland 21215-0036 1972 2 3 ☐ Widowed 4 ☐ Divorced Year or Dates: 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation Completed 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) permit. Pages 1 and 2 should be filed within 7. Department of Health and Mental Hygiene. Important: If them 27 is marked other than "na any injury or other traumatic event and once." College (1-4or 5+) **USAF** Elementary/Secondary (0-12) Pilot 12 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Daisy Jamie Rennie William ည 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State 6709 Berkshire Drive, Temple Hills, MD 20748 19a. Informant's Name/Relationship (Type. Print) Lola C. Rennie (Wife) 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20a. Method of Disposition 1 ☐ Burial 2 X Cremation 3 ☐ Removal from State Clinton, Maryland Dec 22, 2009 Lee Crematory 4 □ Donation 5 □ Other (Specify) 22. Name and Address of Facility Lee uneral flome, Inc hold 21. Signature Funeral Service Alexandira Ferry Road, Clinton, MD 20735 40015 160 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each liny. Approximate Interval Between Onset and Death 22-1 Immediate Cause (Final VO **Physician** disease or condition resulting in death) consequence of) Due to (or as a /Medical Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner Hospital or Attending Physician: The law requires that the death certificate be executed attending physician and for use as the burial-transit Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, Physician/Medical 23d. Date of delivery IF FEMALE: Year 1 ☐ Live birth 2 ☐ Fetal death 4 ☐ Pregnant at time of death Month Day 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No 5 Other (specify) signed by the ar 23e. Did tobacco use contribute to the cause of death? conditions contributing to death but not resulting in the underlying cause given in Part I. 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 🛣 Unknown Completed by 24b. Were autopsy findings available prior to completion of cause of death?
1 □ Yes 2 ▼ No 24a. Was an autopsy performed has t page 2 1 ☐Yes 2 No After this certificate 26. Place of Death (Check only one) 25. Was case referred to medical examiner? director, Be Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 1 ☐ Yes 2 👿 No Medical Certification: To 28d. Describe how injury occurred 28a. Date of Injury (Month, Day, Year, 28b. Time of 28c. Injury at Work? funeral 27. Manner of Death 5 ☐ Pending investigation 1 Natural 1 ☐ Yes 2 ☐ No 2 Accident 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 6 ☐ Could not be 3 Suicide determined

ours after death.

neral Director: A
filled in by the fu within 24 hours a To the Funeral L completely

4 Homicide

(Check only one)

29b. Signature and titl

31. Date filed (Month, Day, Year)

29a. Certifier

State

death (Item 23a) (Type, Print) of person who completed cause of 30. Name and address Jamil Malout, M.D. 32. Registrar's Signature

23 2009

1 A Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29d. Date signed (Month, Day, Year) 29c. License number Dec 22, 2009 NJ MA42880

> 1050 West Perimeter Road, Andrews, AFB, MD 20762

Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Year **Physician** P^{M} 2009 1230 December 24 Ralph Earl Stewart /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner Ceci1 Elkton Care and Rehabilitation E1kton If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) AUG 25, 19 Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) 5. Social Security Number **Funeral** Days Hours 1**X**0 M 2□ F 1927 Director 214-24-0935 82 Maryland Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 10a State 10b. County in item 27 is marked other then "naturel", or Items 23a or 28a-f show or other freumatic event, the Medical Examinat must be notified at 1 ¥ Yes 2 ☐ No Director Maryland Elk Mills Ceci1 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number 504 Elk Mills Road United States by Funeral Race - American Indian, Black, White, etc. 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11, Marital Status 1 ☐ Yes 2 🏋 No If Yes, Give Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 🎇 No Specify Specify: 3 X Widowed 4 ☐ Divorced White Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) College (1-4or 5+) Elementary/Secondary (0-12) Operator Paper Manufacturing permit. Pages 1 and 2 should be filed to Department of Health and Mental Hygis Important: If Item 27 Is marked other? 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) George Franklin Stewart Helen Harrigan 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) Shirley M. Wheatley/Niece 1053 Jackson Hall School Road, Elkton, MD 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition December 1 ☐ Burial 2 XX Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) R. A. Ferris & Co., Inc. 31, 2009 West Chester, PA 21. Signature of Funeral Service Licensee 22 Name and Address of Facility
Hicks Home for Funerals, P.A.
103 W. Stockton Street, Elkton, Iny 21921 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** rdrao resulting in death) /Medical Due to (or as a consequence of): Examiner gromops Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of Examine funeral director, page 2 should be detached for use as the burial-transi Due to (or as a consequence of) Physician/Medicai 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No 4☐Pregnant at time of death 5 Other (specify) □Yes Division of Vital Records, P.O. 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. ģ 1 ☐ Yes 2 ☐ No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy 2 No 1 ☐ Yes 2 ☐ No the Hospital or Attending Physician: 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: 1 ☐ Inpatient Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 No 2 ER/Outpatient 3□ DOA 28c. Injury at Work? 28a. Date of Injury (Month, Day Year) 28d. Describe how injury occurred 27. Manner of Death 28b. Time of Certification: 1 Natural 2 Accident 5 Pending death. 1 ☐ Yes 2 ☐ No investigation 28f. Location (Street and Number or Rural Roule Number, City or Town, State) 6 Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 | Homicide within 24 hours after To the Funerel Dire 1 Cartifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Madical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 20060756 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) St. 81km, 21921 31. Date filed (Month, Day, Year) State JAN 0 7 2010 Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 20 2^{Year} 20 WALTER H. SCHMIDT December 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Death Baltimore Dulaney Valley Assisted Living Baldwin Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year | If Under 24 Hrs. 8. Date of Birth 1 1 1 1 3 / 9. Birthplace (State or Foreign 75 Months Days Hours Min. 1**½** M 2□ F 473-38-3593 Germany Usual Residence of Decedent 10a. State 10c. City, Town or Location 10b. County 10d. Inside City Limits York 1 ☐ Yes 2 XNo PA Fawn Grove 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 17321 USA 269 Buckwheat Road 12. Was Decedent Ever in U.S. Armed Forces? 1 TXYes 2 □ No If Yes, Give 1 9 5 8 − 6 0 Year or Dates. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 Never Married 2X Married 1 ☐ Yes 21X No Specify: SpeWhite 3 Widowed 4 Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Nuclear Plant Painter 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Wilhelm Schmidt Margaret Feltheusen 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code, 269 Buckwheat Road, Fawn Grove, PA 17321 Hazel D. Schmidt/Wife 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 XBurial 2 ☐ Cremation 3 ☐ F 4 ☐ Donation 5 ☐ Other (Specify) 3 Removal from State Bel Air, MD Bel Air Mem.Gdns. 12/24/09 21. Signature of Jun al Se 22. Name and Address of Facility 600 Main St Harkins Funeral Home, Inc. Kover Delta, PA17314 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. Approximate Interval Between Onset and Death Immediate Cause (Final DEMENTIN ZHEIMERS disease or condition resulting in death) Due to (or as a consequence of): Sequentially list conditions, if any, leading to immediate cause. Erner Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Due to (or as a consequence of) IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Year Day 5 Other (specify) 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 M No 3 ☐ Probably 4 ☐ Unknown Were autopsy findings available prior to completion of cause of death? autopsy performed' 1 ☐ Yes 1 ☐Yes 2 ☐ No 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) ASSISTED 1 Yes 2 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 28a. Date of Injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural 2 Accident 5 Pending investigation 1 ☐ Yes 2 ☐ No

Physician /Medical **Examiner**

Physician

Examiner

Funeral

Director

ir than "natural", or items 23a or 28a-f show the "decical Examiner must be notified at

permit. Pages 1 and 2 should be filed within 72 hours after c Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or iter any injury or other traumatic event, the Modical Experime. once.

Baltimore, Maryland 21215-0036

Director

Funeral

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Completed

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death with the Maryland

/Medical

Examiner

Physician/Medical

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Completed

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Certification: To

ca

3 Suicide

29a. Certifier

4 Homicide

(Check only one)

6 Could not be determined

law requires that the death certificate be executed attending physician been signed has • Hospital or Attending Physician: The 24 hours after death.
• Funeral Director: After this certificate h filled in by the funeral

P.O.

Division of Vital Records,

within 2 To the I State Registrar

29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) Wellerken 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) VOVION AVE HAVREDE GRACE, MD 21078

🗹 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

28f. Location (Street and Number or Rural Route Number, City or Town, State)

Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) Date of Death
 Month **Physician** 2:06 AM John Frederick Spalding, Sr. 21 2009 December /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner St. Mary's St. Mary's Hospital Leonardtown If Under 1 Year | If Under 24 Hrs. 9. Birthplace (State or Foreign 5. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) **Funeral** Days Months Hours 1 ☑ M 2 ☐ F 217-36-7767 75 Maryland December 10,1934 Director Usual Residence of Decedent filed within 72 hours after death with the Maryland 10d. Inside City Limits 10a. State 10c. City, Town or Location d other than "natural", or items 23a or 28a-f show event, the Medical Eva., item must be notified at Leonardtown St. Mary's 1X Yes 2 □ No Maryland Director 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number USA 20650 22670 Budds Creek Road Funeral 14. Race - American Indian, Black, White, etc. 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 1 ☐ Yes 2 X No If Yes, Give Year or Dates: 1 Never Married 2 Married Saltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify: White 2 3 ☐ Widowed 4 K Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry I Hygiene. other than "r Elementary/Secondary (0-12) College (1-4or 5+) Farming 8 Tobacco Farmer 7 is marked other traumatic event, to 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be h and Mental F should be Mary Louise Raley George Felix Spalding ပ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) P.O. Box 422 Leonardtown, MD 20650 James Edwin Spalding /Brother 27 Department of Health Important; If item 27 any injury or other to once. 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition Pages 1 December 30 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State Leonardtown, Maryland Charles Memorial 2009 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility
Mattingley-Gardiner Funeral Home,
P.O. Box 270 Leonardtown, MD 206 Leonardtown, MD 20650 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician ARREST MINUTES CARDIAC disease or condition resulting in death) / /Medical Due to (or as a consequence of): Examiner WEEKS Sequentially list conditions, if any, leading to immediate cause. Litter Underlying Cause (Disease or injury that initiated events Due to (or as a consequence of): death certificate be executed FARS Exami ABETES physician and the burial-tran resulting in death) Last Due to (or as a consequence of) Physician/Medical IF FEMALE: use 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 - Ectopic pregnancy in the past 12 months? Month Year Day 5 Other (specify) been signed by the hould be detached 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Records. Completed by 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an cate has autopsy performed? Yes 2 No certificate 1 □ Yes Vital director, 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 | Inpatient 2 ER/Outpatient 3 □ DOA this Medical Certification: To of 28a. Date of Injury (Month, Day, Year) 27. Manner of Death 1 Natural 2 ☐ Accident To the Hospital or Attending Pr within 24 hours after death. To the Funeral Director: After th completely filled in by the funeral 28b. Time of 28d. Describe how injury occurred 28c. Injury at Work? Division 5 ☐ Pending investigation 1 ☐ Yes 2 ☐ No Location (Street and Number or Rural Route Number, City or Town, State) 3 ☐ Suicide 6 ☐ Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) determined 4 ☐ Homicide 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) MD D0068989 énle 30. Nam- and address of person who commeted cause of death (Item 23a) (Type, Print) Box 524 Leonardton MD 20650 ROGBEMI BABATUNDE 31. Date filed (Month, Day, Year) 32. Registrar's Signature State DEC 2

DHMH 17 Rev 1/2001

Registrar

ORIGINAL

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death . Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Car1 Schneider, Jr. 6:30 A M 2009 Dec<u>ember</u> Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Prince George's 13007 Midsummer Lane Bowie If Under 1 Year | If Under 24 Hrs. Social Security Number 8. Date of Birth 9. Birthplace (State or Foreign 7. Age (In vrs. last birthday) Funeral Days Hours (Month, Day, Year) Director 217-34-1336 72 Yrs. 1937 Marvland Usual Residence of Decedent 10b. County 10c. City, Town or Location 10d. Inside City Limits Page 1 and 2 should be filed within 72 hours after death with the Maryland ment of Health and Mental Hygiene.
ant: If item 27 is marked other than "natural", or items 23a or 28a-f sho ury or other traumatic event, the Medical Examiner must be notified at Director Prince George's 1 X Yes 2 □ No Marvland Bowie 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 8716 Race Track Road U.S.A. 20715 12. Was Decedent Ever in U.S.
Armed Forces?

1 ☒ Yes 2 ☐ No
If Yes, Give 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc 1 Never Married 2 Married Completed by Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify: Specify: 3 X Widowed 4 ☐ Divorced White Year or Dates. 1957-58 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) Grocery Clerk Giant Food Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ပ Helen Car1 Schneider, Sr. Elizabeth 19a, Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) James A. Schneider/Son 13007 Midsummer Lane, Bowie, Maryland Department of Health Important: If item 27 any injury or other to once. 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Date 1 Burial 2 X Cremation 3 Removal from State 12/15/2009 Glen Burnie, Maryland 4 ☐ Donation 5 ☐ Other (Specify) Atlantic Crematory 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Robert E. Evans Funeral Home, 16000 Annapolis Road, Bowie, Maryland 20715 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Physician/ Bronchosonic

Due to (or as a construence of): vears disease or condition Medical resulting in death) Examiner Sequentially list conditions, Examine Due to (or as a consequence of) if any, leading to immediate cause. Enter Underlying physician and the burial-transit Hospital or Attending Physician: The law requires that the death certificate be executed Cause (Disease or linjury that initiated events Due to (or as a consequence of): resulting in death) Last Physician/Medical Division of Vital Records, P.O. Box 68760 attending p IE EEMALE 23c. If yes, outcome of pregnancy 1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery Live Birth 2 L recarded
Pregnant at time of death 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ in the past 12 months? Month Day Year 2 No been signed by the should be detached 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by Obstructive 1 Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an page 2 After this certificate has autopsy 1 Yes 2 No Yes 25. Was case referred to medical examiner? funeral director, Be 26. Place of Death (Check only one) Hospital 2 No Other: မ 1 🗌 Yes 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 4 ☐ Nursing Home 5 ☐ Residence 6 🔀 Other (Specify) Son's 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at Certificate: 28d. Describe how injury occurred Residence work? injury 1 Natural 5 Pending after death.

Director: Af
d in by the fur Accident Investigation 6 Could not be Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 28f. Location (Street and Number or Rural Route Number, completed filled in by determined City or Town, State) Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 12-11-2009 00012015 30. Name and address of person who completed cause of death (tter 23a) (Type, Print)

State Registrar

541

Landover Rd Chouery, MD 20785

6492

32. Registrar's Signature

Steinberg

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SpowA491e, Thomas D. Maryland 21215-0036

			Pleas	se Type or Print in State of Maryla				-		gible.		
	for State Registrar					ertificate of	Reg. No. 2119 L2713					
	Division	/	1. Decedent's Name (First, Middle, Last)					2. Date of Death 3. Time of Death				
	Physicia Medic		Thomas Duane			December 12 y		1009	4:01 PM			
)	Examin	er	4a. Facility Name (if not institution, give street and number) Doctor's Community Hospital			4b. City, Town, or Location of Death Lanham				ce Geo	George's	
	Funeral Director		215-54-5415	. Sex 1 ☑ M 2 ☐ F 7. Age (In yrs	s. last birthda Yrs.	Months Days		8. Date of Bird (Month, Da Nov 10	of Birth h , D ay, Y ear) 10 , 1954 Was		place (State or Foreign try) ington, D.C.	
	nd thow	ا ة	Usual Residence of Decedent 10a. State 10b. County 10c. City, Tow			Location			1	0d. Inside City Limits		
	Maryla 28a-f s stiffed	rect	Maryland Prince George's Bowie								1 🗶 Yes 2 🗌 No	
030	1 and 2 should be filed within 72 hours after death with the Maryland of Health and Mental Hygiene. The Health and Mental Hygiene. The same 27 is marked other than "natural", or items 23a or 28a-f show other traumatic event, the Medical Examiner must be notified at	Funeral Director	10e. Street and Number 12519 Chelton Lane			10f. Zip Code 20715		10g. Citizen of What Country? U.S.A.				
		Completed by Fun	11. Marital Status 1 □ Never Married 2 ☒ Married 3 □ Widowed 4 □ Divorced 12. Was Decedent Ever in U.S. Armed Forces? 1 □ Yes 2 ☒ No If Yes, Give Year or Dates.			Was Decedent of Hispanic Origin? (Specify Yes of If Yes, specify Cuban, Mexican, Puerto Rican, etc.) □ Yes 2 ☑ No Specify:			14. Race - American Indian, Black, White, etc. Specify: White			
9500-612			15. Decedent's Education (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+)			Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)			16b. Kind of Business Industry U. S. Postal			
77	ygiene ygiene her th	Be Co	1 Postal Clerk				1	Service				
yland	be filer ental H rked ot ic ever	PB B	17. Father's Name (First, Middle, Last) Duane Eugene Sponaugle				e (First, Middle, Maiden Surname) Lorraine Davis					
Mary	permit. Page 1 and 2 should Derartment of Health and M Imrortant: If item 27 is mar amy injury or other traumat		19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, Stat						State, Zip 0			
Baitimore,			20a. Method of Disposition 2									
Balt			21. Signature of Funeral Service Licensee 22. Name and Address of Facility Robert E. Evans Funeral Home									
,			23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate								Approximate	
4	ำเงูร์เฉ่สก/		shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition a.				risease			Interval Between Onset and Death		
	Medical Examiner		resulting in death) Due to (or as a consequence of):									
	ted nsit	Examiner										
	e death certificate be executed the attending physician and hed for use as the burial-transit											
3/6/		Nedi	d.									
Box 68/60		Physician/Medical	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown	1 Live Birth 2 🗆 F	23c. If yes, outcome of pregnancy 1 ☐ Live Birth 2 ☐ Fetal death 3 ☐ Ectopic pregnancy 4 ☐ Pregnant at time of death 5 ☐ Other (specify) 9 ☐ Unknown				23d. Date of delivery Month Day Year			
л Э	that th	by Ph	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.					23e. Did tobacco use contribute to the cause of death?				
as,	quires en sign ould be	ted k	chronic hejatitis					1 ☐ Yes 2 ☑ No 3 ☐ Probably 4 ☐ Unknown			bably 4 🗌 Unknown	
Vital Records,	To the Hospital or Attending Physician: The law requires that the death certificate be within 24 hours after death. within 24 hours after death. To the Funeral Director. After this certificate has been signed by the attending physici completed filled in by the funeral director, page 2 should be detached for use as the bu	Completed	circhosis				perfo	Was an autopsy performed? Yes 2 ☑ No 24b. Were autopsy findings available prior to completion of cause of death? Yes 2 ☑ No 1 ☐ Yes 2 ☐ No				
<u>a</u>		BeC	25. Was case referred to medical examiner?									
IN OT VI		은	1 Yes 2 No Residence 6 Other Speci)	
		icate	1			y wor M 1	28d. Describe how injury occurred					
DIVISION	al or Atte s after der al Director ed in by th	Certificate:	3 Suicide 6 Could no 4 Homicide determin	28e. Place of injury - At	Place of Injury - At home, farm, street, factory, office building, etc. (Specify)			28f. Location (Street and Number or Rural Route Number, City or Town, State)				
	he Hospit in 24 hour he Funera	Medical	29a. Certifier (Check only one) 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.									
	Voith To 1		29b. Signature and title of certifler 29c. License number 27 3583					29d. Date signed (Month, Day, Year)				
	50		30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Peter Ecicles M.D. 14300 Gallant For Lane #10 Bowie, MD 20715									
	Star Registra	te	31. Date filed (Month, Day, Year) 20									

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 42714 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month Year Paver Stevens 1:32 P M 2009 12 Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Baltimore Washington Medical Arunde Burnie Anne 5. Social Security Number 6 Sex 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Birthplace (State or Foreign Country) **Funeral** Months Hours 1 🔀 M 2 🗆 F 80 Director 14,1929 566-38-7888 Arizóna Nov. Usual Residence of Decedent 10b. County 10a. State 10c. City, Town or Location 10d. Inside City Limits ä Director ural", or items 23a or 28a-f s Examiner must be notified Anne Arundel Severna Park MD 1 Tes 2 X No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 477 London Lane 21146 USA 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. Black, White, etc ģ 1 Never Married 2 Married ☐ Yes 2 🔀 No Yes, Give Page 1 and 2 should be filed within 72 hours after Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify: White Specify: "natural", Completed 3 XWidowed 4 Divorced Year or Dates Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natur any injury or other traumatic event, the Medical. 15. Decedent's Education 16a, Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired)

Episcopal Elementary/Seconday (0-12) College (1-4 or 5+) Self-Employed Psychoanalyst/ Priest Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Wilma Weaver Frank Stevens 19a. Informant's Name/Relationship (Type, Print) Stevens 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Severna Park, MD 21146 Anne L. Pickup / Partner 477 London Lane 20a. Method of Disposition Date 15, 20b. Place of Disposition (Name of 20c. Location - City or Town, State 1 ☐ Burial 2 🔀 Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) cemetery, crematory or other place) Dec. Baltimore, MD Metro Crematory, INC 2009 Signature of Funeral Service Licensee 22. Name and Address of Facility Barranco & Sons, 495 Gov. Ritchie P.A. Severna Park Funeral Home Hwy, Severna Park, MD 21146 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Immediate Cause (Final Physician myocardial disease or condition Medical resulting in death) Due to (or a a consequence of) Examiner 3 -4 days Sequentially list conditions, Examine Duvitu fur as a nur evalur in if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury that initiated events sician and burial-transit Hospital or Attending Physician: The law requires that the death certificate be executed Due to (or as a consequence of): resulting in death) Last the attending physician Physician/Medical Division of Vital Records, P.O. Box 68760 as the IF FEMALE: nse 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 Ctopic pregnancy
5 Other (specify) for in the past 12 months?
1 ☐ Yes 2 ☑ No Month Day Year 9 Unknown signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Be Completed by hypertension. 1 ☐ Yes 2 🗹 No 3 ☐ Probably 4 ☐ Unknown peen 24b. Were autopsy findings available 24a. Was an prior to completion of cause of death? has performed? Yes 2 No 24 hours after death.

Funeral Director: After this certificate 1 ☐ Yes 2 ☐ No completed filled in by the funeral director, 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify, Certificate: To 1 Tyes 24 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 X DOA 27. Manner of Death 28a. Date of injury 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 🗷 Natural (Month, Day, Year) work? 1 ☐ Yes 2 ☐ No 5 Pending Investigation Accident Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Medical 29a. Certifier 🗹 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 🗆 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated within 2 To the F only one) Girtifying Nurse Frectioner To the best of my knowledge, death oncome id at the time, date and place, and due to the nause(s) and mannin as state 29b. Signature and title of certifie 29c. License number 29d. Date signed (Month, Day, Year) leux Bulting 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) S. Peairs FAILS Road Suite 325 Hopkins Greenpring Station - 10753 Johns at 31. Date filed (Month, Day, Year) 32. Fegistrar's Signature 17 2009

DHMH 17 Rev 7(2:10)

Registrar

State

Registrar

31. Date filed (Month, Day, Year)

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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State
 Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ 8:00 рм Sherman 2009 Seymour December Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Montgomery General Hospital Montgomery Olney Social Security Number . Age (In vrs. last birthday) If Under 1 Year If Under 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** Year 921 1 X M 2 - F Months Days Hours June 20 Connecticut Director 146-24-5822 88 Usual Residence of Decedent ral", or items 23a or 28a-f show Examiner must be notified at permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f sho any injury or other traumatic event, the Medical Examiner must be notified at 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director 1 Yes 2 No Silver Spring Maryland Montgomery 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 15010 Eardley Court. 20906 U.S.A. 12. Was Decedent Ever in U.S. Armed Forces? 1 Ⅺ Yes 2 ☐ No 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Black, White, etc. þ 1 Never Married 2 X Married Baltimore, Maryland 21215-0036 If Yes, Give Year or Dates. 1 Yes 2 X No Specify. Specify: Completed 3 Widowed 4 Divorced White WWII 15. Decedent's Education 16a, Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) Package Store Owner Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Samuel Sherman Katherine Goldman 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 3927 Prospect Street, Kensington, Maryland 20895 Nancy Sherman - Daughter 20b. Place of Disposition (Name of cemetery, crematory or other place 20a. Method of Disposition 20c. Location - City or Town, State Date 1 X Burial 2 Cremation 3 Removal from State Judean Memorial Gdns. 12/17/2009 4 Donation 5 Dother (Specify) Olney, Maryland 22. Name and Address of Facility Hines-Rinaldi Funeral Home. 11800 New Hampshire Ave., Silver Spring. MD23a. Part J. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Onset and Death Immediate Cause (Final Physician/ DOWE disease or condition Medical resulting in death) Examiner Sequentially list conditions Examine if any, leading to immediate cause. Enter Underlying Cause (Disease or linjury that initiated events within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completed filled in by the funeral director, page 2 should be detached for use as the burial-transit Hospital or Attending Physician: The law requires that the death certificate be executed resulting in death) Last Due to (or as a consequence of) Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregna 5 Other (specify) Ectopic pregnancy in the past 12 months? Pregnant at time of death 2 🗌 No 1 Yes 2 L 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Be Completed by 1 Yes 2 No 3 Probably 24b. Were autopsy findings available prior to completion of cause of death? 24a Was an autopsy performe 1 Yes 2 No 2 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Hospital: Other: Certificate: To 1 Yes 1 Inpatient 2 ER/Outpatient 3 DOA 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) Manner of Death 28a. Date of injury 28b. Time of 28c. Injury at work? 1 Natural (Month, Day, Year) 5 Pending 1 ☐ Yes 2 ☐ No Accident Investigation 3 Suicide 4 Homicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Medical 1-Acertifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier To the 29b. Signature and title of certifier

Registrar
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31. Date filed (Month, Day, Year DEC 17

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Hospital

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) December 10,2009 10:45 A. M **Physician** Henning Schonwandt /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner 3203 Parkview Road Montgomery Chevy Chase B. Date of Birth June 18, 5. Social Security Number If Under 1 Year | If Under 24 Hrs. 9. Birthplace (State or Foreign (In vrs. last birthday) 6. Sex **Funeral** Months Days Hours Min. 80 Latvia 1 □XM 2 □ F 213-44-5875 Director Usual Residence of Decedent filed within 72 hours after death with the Maryland 10d. Inside City Limits 10a. State 10b. County 10c. City, Town or Location ir than "natural", or items 23a or 28a-f show the Medical Examinar must be notified at Chevy Chase MD Montgomery 1XYes 2 No Director 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number 3203 Parkview Road 20815 Canada Completed by Funeral Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14 Race - American Indian. 11. Marital Status Black, White, etc. 1 X Never Married 2 ☐ Married Maryland 21215-0036 White 1∐Yes 2**∑**No Specify. al Hygiene. other than "natural", 3 Widowed 4 Divorced 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) consultaning Consultant permit. Pages 1 and 2 should be filed Department of Health and Mental Hyg Important: If item 27 is marked other any injury or other traumatic event, 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Paul Frederick Ella Herring ၉ 19b Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)
Penn Valley, PA 19072 19a. Informant's Name/Relationship (Type. Print) Tobias Schonwandt/Nephew Baltimore, 20b. Place of Disposition (Name of Georgetown Company of the place) ty Medical Center 2009 20a. Method of Disposition 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State Washington, D.C. 4X Donation 5 ☐ Other (Specify) 22. Name and Address of Facility Columbia Mortuary Services, P.A. 9013 Annapolis Road, Lanham, MD 20706 21. Signat@elof Funeral Service Licensee Lutere Poucox 70685 Approximate Interval Between Onset and Death 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final cirrhosi **Physician** months disease or condition resulting in death) /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Due to (or as a consequence of) Examiner Physician: The law requires that the death certificate be executed for use as the burial-trar resulting in death) Last Due to (or as a consequence of) attending physician Division of Vital Records, P.O. Box 68760 Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live birth 2 Fetal death
4 Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months? 3 Ectopic pregnancy 5 ☐ Other (specify) 1 ☐ Yes 2 ☐ No cate has been signed by the page 2 should be detached 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Be Completed by 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a, Was an autopsy performed? 1 □ Yes 2 No certificate 1 ☐ Yes 2 ☐ No Anemia completely filled in by the funeral director, 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: Other: 4 \(\Bigcap \) Nursing Home 1 Yes 2 No 5 Residence 6 □ Other (Specify) 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Medical Certification: To 27. Manner of Teath 28a. Date of Injury (Month, Day, Year) 28c. Injury at Work? 28d. Describe how injury occurred or Attending 1 Alatural 5 Pending To the Hospital or Attendii within 24 hours after death. To the Funeral Director: A investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 3 🗌 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide 29a. Certifier ertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifier 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) MO 31. Date filed (Month, Day, Year) 32/Registrar's Signature **DEC 17** Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month Day Vear G. SCHLUB 0930AM ATRICIA 2000 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death MED CTR BARTIMORE UNIVERSITY OF MULLZYCAND If Under 1 Year If Under 24 Hrs. 8. Date of Birth Months Days Hours Min. Feb. 24, 1947 Social Security Number 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign 6. Sex 154-38-9372 1 □ M 2 🛛 F New Jersev 62 Usual Residence of Decedent 10b. County 10c. City, Town or Location 10d. Inside City Limits Maryland Prince George's Beltsville 1 ☐ Yes 2X No 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 13110 Taney Drive 20705 United States Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14 Bace - American Indian. 1 ☐ Never Married 2 ☐ Married 1 ☐ Yes 🏖 ☐ No Specify: White 3 Widowed 4 Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Medical Technologist V.A. Hospital 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) John G. Costello Grace Odell 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 14167 Paris Breeze Place Purcellville, Virginia 20132 Jennifer L. Fazio -daughter 20a. Method of Disposition
1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State Metropolitan Crematory12/15/2009 Alexandria, Virginia 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee Donald V. Borgwardt Funeral Home, PA 4400 Powder Mill Road Beltsville, Maryland 20705 Approximate Interval Between Onset and Death 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. DISTRESS SYNDROME ACUTE Immediate Cause (Final RESPIRATORY disease or condition resulting in death) LEUKEMIA Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): IF FEMALE: 23c. If yes, outcome of pregnancy 23b. Was decedent pregnant 23d. Date of delivery 1 Live birth 2 Fetal death 4 Pregnant at time of death in the past 12 months? 3 Ectopic pregnancy Month Day Year 5 Other (specify) Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? MYOLARDIAR 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? Yes 2 No 2 12 No 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 Inpatient

Physician /Medical Examiner

Physician

Examiner

Funeral

Director

d other than "natural", or items 23a or 28a-f show event, the Medical Examiner must be notified at

nd 2 should be filed within alth and Mental Hygiene.
27 Is marked other than "

permit. Pages 1 and 2 st Department of Health and Important: If item 27 Is n any injury or other traun

filed within 72 hours after death with the Maryland

Baltimore, Maryland 21215-0036

/Medical

10a. State

Director

Funeral

Completed by

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The law requires that the death certificate be executed burial-tra Division of Vital Records, P.O. Box 68760 physician the use as the cate has been signed page 2 should be deta certificate has or Attending Physician: funeral director

After this

To the Hospital or Attend within 24 hours after death To the Funeral Directors.

Examiner Physician/Medical þ Completed Be Certification: To filled in by the

9 Unknown

25. Was case referred to medical examiner? 1 Yes 2 No

> 5 Pending investigation 6 ☐ Could not be

determined

28a. Date of Injury (Month, Day, Year) Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

2 ER/Outpatient 3 DOA 28b. Time of

28c. Injury at Work? 1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred 28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

27. Manner of Death 1 ★ Natural 2 ☐ Accident

3 ☐ Suicide

4 Homicide

Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier

29c. License number

29d. Date signed (Month, Day, Year)

Documber 11, 2009

30 Name and address of person who completed cause of death (Item 23a) (Type, Print) 22 SCUTH GREENE ST BATTINGE ND SHEINGELD MID

State Registrar

31. Date filed (Month, Day, Year)

37. Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ SEPH Medical 4b. City, Town, or Location of Death Beltsville 4a. Facility Name (if not institution, give street and number, Ac. County of Death
Prince George's Examiner 11002 Emack Road 7. Age (In yrs. last birthday) 52 yrs. 5. Social Security Numbe If Under 1 Year If Under 24 Hrs 8. Date of Birth 9. Birthplace (State or Foreign Sex 1 M 2 □ F **Funeral** Months Days Hours Min 217-72-3238 Janth, Pay 1 937 Washington, DC Director Usual Residence of Decedent item 27 is marked other than "natural", or items 23a or 28a-f show other traumatic event, the Medical Examiner must be notified at 10b. County 10c. City, Town or Location 10d. Inside City Limits should be filed within 72 hours after death with the Maryland Director Beltsville Maryland Prince George's 1 ☐ Yes 2 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 20705 United States 11002 Emack Road 11 Marital Status 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-14 Race - American Indian Armed Force If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Black, White, etc. þ 1 Never Married 2 Narried ☐ Yes 2 🛛 No Baltimore, Maryland 21215-0036 1 Yes 2 No If Yes, Give Specify White Completed 3 Widowed 4 Divorced Year or Dates 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15 Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) Page 1 and 2 should be filed within 72 ment of Health and Mental Hygiene. ant: If item 27 is marked other than ' Elementary/Seconday (6-12) College (1-4 or 5+) Automotive Mechanic Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ပ Joann Rhodes Chester J. Salute 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Donna J. Salute -wife 11002 Emack Road Beltsville, Maryland 20705 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date permit. Page 1 s
Department of H
Important: If ite
any injury or ot 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Gate of Heaven Cemetery 12/16/2009 SilverSpring, Maryland 21. Signature of Funeral Service Licenses ²b୪୩a1d⁴∜େ Bōrgwardt Funeral Home, PA 4400 Powder Mill Road Beltsville, Maryland 20705 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between Onset and Death shock, or heart failure. List only one cause on each line Immediate Cause (Final Physicians disease or condition resulting in death) omos Medical Due to (or as a conse u ence of) Examine Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examine Due to (or as a consequence of) the Hospital or Attending Physician: The law requires that the death certificate be executed as the burial-transi Cause (Disease or linjury attending physician and that initiated events resulting in death) Last Due to (or as a consequence of) Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: for use If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death
9 ☐ Unknown 23b. Was decedent pregnant 23d Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ in the past 12 months? Day 1 Yes 2 No the detached r signed by the Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ۾ 2 No 3 Probably 4 Unknown Completed director, page 2 should 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an certificate has autopsy nerform 1 Yes æ 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 No မ 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA after death. 28a. Date of injury (Month, Day, Year) filled in by the funeral Certificate: 27. Manner of Death 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 Natural work? 1 ☐ Yes 5 Pending 2 🗌 No Investigation 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) within 24 hours a To the Funeral C Medical 1 Sertifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier (Check Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 3 only one Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated

State Registrar 29b. Signature and title of certifie

31. Date filed (Month, Day, Year)

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30. Name and address of person who completed cause of death (Item 23a) (Type, Prir

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29d. Date signed (Month, Day, Year)

1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician Month Myrtie Marie Svor 12, 2009 December 8:00 a /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City. Town, or Location of Death Examiner 495 Tremont Drive, apt 8 Westminster Carroll 5. Social Security Number If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) **Funeral** Months Min. 1 □ M 2 1 F Days Hours 218-22-5380 87 Director Feb 4, West Virginia 1922 Usual Residence of Decedent 10a State 10h. County 10c. City, Town or Location 10d. Inside City Limits show ortant: If item 27 is marked other than "natural", or items 23a or 28a-f show injury or other traumatic event, the Medical Examination must be notified at Director 1 Yes 2 No Maryland Carroll Westminster 10e. Street and Number 10g. Citizen of What Country? 10f. Zip Code 495 Tremont Drive, apt 8 21157 Funeral USA Pages 1 and 2 should be filed within 72 hours after death vnent of Health and Mental Hygiene. 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☐ No If Yes, Give Year or Dates: 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 11. Marital Status 1 Never Married 2 Married 1 □Yes 2 No Specify þ Specify: 3 Widowed 4 □ Divorced white Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) of Health and Mental Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) Own Home 11 Homemaker 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) German Bolen Mittie Okes ပ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Judy A. Streib, daughter 920 Arnold Road, Westminster, MD 21157 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State Date permit. Pages
Department o
Important: If
any Injury or
once. 1 Burial 2 ☐ Cremation 3 ☐ Removal from State 12/15/2009 Middle River, MD Holly Hill Memorial 4 Donation 5 Other (Specify) Signature of Funeral Service License 22. Name and Address of Facility Myers-Durboraw Funeral Home 91 Willis Street, Westminster, MD 21157 Part . Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final Physician disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner e Hospital or Attending Physician: The law requires that the death certificate be executed 24 hours after death. Funeral Director: After this certificate has been signed by the attending physician and letely filled in by the funeral director, page 2 should be detached for use as the burial-transit Due to (or as a consequence of): by Physician/Medical IF FEMALE: If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant in the past 12 months? 23d. Date of delivery 3 Ectopic pregnancy Month Day Year 5 Other (specify) ☐Yes 2 No 9 Dunknown 9 I Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 12 No 1 Tes 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 Yes 2 No 24a. Was an autopsy performed? Yes 2 No 1 ☐ Yes Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) 2 No Hospital: Other: 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) Certification: To 1∐Yes 1 Inpatient 2 ER/Outpatient 3 DOA 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of Injury 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural 2 Accident 5 Pending investigation 1 ☐ Yes 2 ☐ No 6 ☐ Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) Medical 29a Certifier and manner stated. To the within 2 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) D 25052 NJL ss of person who completed cause of death (Item 23a) (Type, Print) 30. Name and addr 5 RUSSROPIDS State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Year 0 830PM **Physician** Jane maru /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner montgomen 1830 MO Georgia Olnei If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** 1 □ M 2 1 F Months Days Hours Min. DC **Director** 214-34-6303 03/17/1932 Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits 28a-f show permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryla Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, it whealcal Evantmer must be notified at Director 1 XYes 2 ☐ No MD Olney Montgomery 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 18301 Georgia Avenue 20832 USA Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☐ No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Race - American Indian. 1 ☐ Never Married 2 ☐ Married 1 ☐ Yes 2 🛣 No Specify. δ Specify: 3 ☐ Widowed 4 🕅 Divorced Black Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Nurse Upjohn 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Louis Lee Nellie Clipper ပ္ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Paulette Shelton - daughter 18104 Rolling Meadow Way, Olney, MD 20832 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 N Burial 2 ☐ Cremation 3 ☐ Removal from 4 ☐ Donaţion 5 ☐ Other (Specify) 12/22/09 Suitland, MD ln Mem. Cem. 21. Signature of Funeral Service Liounse 22. Name and Address of Facility Snowden Funeral Home any in 246 N. Washington St, Rockville, MD 20850 23a. Part 1. Enter the diseas shock, or heart failure e, or complications that caused the death. List only one cause on each line. not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** myocardial days disease or condition resulting in death) /Medical Due to or as a consequence of): Examiner ovonavy Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examiner Due to (or as a consequence of): that initiated events resulting in death) Last ician and burial-trans physician s the burial Physician/Medical attending p for use as t IF FEMALE: 23c. If yes, outcome of pregnancy 23b. Was decedent pregnant 23d. Date of delivery in the past 12 months? Live birth 2 Fetal death
Pregnant at time of death 3 Ectopic pregnancy Month Day Year 5 Other (specify) ed by the detached 9 Unknown s been signed b should be deta Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 ☐ Yes 2 No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☐ No 24a. Was an page 2 autopsy perform certificate 2 No 1 ☐ Yes After this certification funeral director, p 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1∐Yes 2XNo 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Medical Certification: To 28a. Date of Injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 1X Natural 5 Pending investigation 1 ☐ Yes 2 🗆 No 2 Accident filled in by the 3 ☐ Suicide 6 ☐ Could not be determined

Hospital or Attending Physician: The law requires that the death certificate be executed Box 68760, Ö Records, Division of Vital within 24 hours after death.

To the Funeral Director: A completely

To the I

Baltimore, Maryland 21215-0036

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 12 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier

29b. Signature and title of certifier

18

31. Date filed (Month, Day, Year)

(Check only one)

29d. Date signed (Month, Day, Year)

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

D0156784 12,16-09

8210 Colonial Lane Silver Spring MD 20910

Margaret Chang

32 Registrar's Signature

State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death Reg. No. 🤈 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Theodore SITKOFF Month 2009 December 2:49 Р Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death Montgomery Shady Grove Adventist Hospital Rockville Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign Funeral (Month, Day, Months Hours Min. Pennsylvania Director 161-28-0546 Jan Usual Residence of Decedent or 28a-f shov notified at 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director Rockville 1 🗆 Yes 2 🕅 No Maryland Montgomery 10e. Street and Number ŏ 10f. Zip Code 10g. Citizen of What Country? 27 is marked other than "natural", or items 23a or traumatic event, the Medical Examiner must be 20850 Funeral 12910 Cleveland Drive United States 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Armed Forces?

1 X Yes 2 No If Yes, Give Black, White, etc. þ 1 ☐ Never Married 2 🌠 Married Baltimore, Maryland 21215-0036 white 1 ☐ Yes 2 X No Specify: Specify: 3 Divorced 4 Divorced Completed Year or Dates. Korean 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) Public Administrative d Mental Hygiene. marked other than Elementary/Seconday (0-12) College (1-4 or 5+) 5+ CPA/Executive Director Service Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ပ Joseph Sitkoff Sarah Kaliser 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) f Health a item 27 i Fred Sitkoff, Son 2915 Peregoy Drive, Kensington, MD permit. Page 1 and 2 Department of Health Important: If item 27 any injury or other tr 20a. Method of Disposition 20b. Place of Disposition (Name of Date 20c. Location - City or Town, State 1 XBurial 2 Cremation 3 X Removal from State cemetery, crematory or other place) 4 ☐ Donation 5 ☐ Other (Specify) Crescent Memorial Park 12/17/09 Pennsauken, NJ Torchinsky Hebrew Funeral Home 23a. Part Lenter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. 20012 Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ Pancreatic Cancer) Medical resulting in death) Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examine Due to (or as a consequence of): the burial-transi Cause (Disease or iinjury and that initiated events resulting in death) Last Due to (or as a consequence of): ding physician Physician/Medical Division of Vital Records, P.O. Box 68760 use as IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ in the past 12 months?

1 Yes 2 No Pregnant at time of death Unknown Month 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ρ 2 No 3 ☐ Probably 4 ☐ Unknown Completed 24a. Was an . Were autopsy findings available prior to completion of cause of autopsy performed? Yes 2 A No death? 1 ☐ Yes 2 ☐ No To the Hospital or Attending Physician: within 24 hours after death.

To the Funeral Director, After this certific completed filled in by the funeral director, 25. Was case referred to medical æ 26. Place of Death (Check only one) examiner? 1 🗌 Yes 2 No Other: ည 1 X Inpatient 2 - ER/Outpatient 3 - DQA 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 27. Manner of Death 28a. Date of injury (Month, Day, Year) Certificate: 28b. Time of 28c. Injury at work? 28d. Describe how injury occurred Natural 5 Pending 1 Yes 2 🗆 No Investigation 6 Could not be Accident Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 28f. Location (Street and Number or Rural Route Number determined City or Town, State, Medical 29a, Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 3 🗌 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated only one 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) 12/17/09 53177 30+1 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

State Registrar 31. Date filed (Month, Day, Year)

18

John M. Wallmark, M.D., 9707 Medical Center Drive, Suite 300, Rockville, MD

20850

Please Type or Print in Black Indelible Ink Fnsure All Capies Are Legible.
Amend Item 25 per phys. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Day **Physician** CARTER FRANCIS SWANN ccember /Medical Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner LATA MEDICAL If Under 1 Year | If Under 24 Hrs. Social Security Number 9. Birthplace (State or Foreign 6. Sex 7. Age (In yrs. last birthday) 8. Date of Birth **Funeral** SEPTEMBER 2.1929 1 ₹M 2 □ F Months Days Hours Min. MARYLAND 216-22-3433 80 Director Usual Residence of Decedent 10d. Inside City Limits 10b. County 10c. City, Town or Location 10a, State 28a-f show permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryla Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, It is Medical Exercises must be neutified at 1 ▼ Yes 2 □ No Director NANJEMOY MARYLAND CHARLES 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number UNITED STATES 9140 BOWIE ROAD 20662 Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian 11. Marital Status Black, White, etc. 1 ☐ Never Married 2 Married Baltimore, Maryland 21215-0036 1 □ Yes 2 X No Specify: Specify: BLACK ģ 3 Widowed 4 Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) $\begin{array}{c} \text{Elementary/Secondary (0-12)} \\ 12TH & GRADE \end{array}$ College (1-4or 5+) ORDNANCE SPECIALIST FEDERAL GOVERNMENT 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be RUTH BROOKS SWANN **GODFREY SWANN** ည 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) GERALDINE C. SWANN / WIFE 9140 BOWIE ROAD, NANJEMOY, MARYLAND 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition 1 M Burial 2 ☐ Cremation 3 ☐ Removal from State ST. CHARLES CEMETERY DECEMBER 28,2009 GLYMONT, MARYLAND 4 ☐ Donation 5 ☐ Other (Specify) THORNTON FUNERAL HOME, P.A. 3439 LIVINGSTON ROAD, INDIAN HEAD, MARYLAND 20640 21. Signature of Funeral Service Libensee LYDIA C. THORNTON JOHNSON MO0583 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Respiratory Immediate Cause (Final Acrete **Physician** disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner that the death certificate be executed Clustridium and burial-trar Due to (or as a consequence of) Box 68760. Physician/Medical the attending pl IF FEMALE: 23b. Was decedent pregnant 23d. Date of delivery Live birth 2 Fetal death
Pregnant at time of death 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 5 Other (specify) Ö 9 Unknown signed I Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Records, icate has been siç r, page 2 should b 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 □Yes 2 □No 24a. Was an autopsy perform certificate 2 No Division of Vital director, 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1∐Yes 2**X**No 1 Inpatient 2 ER/Outpatient 3 DOA Medical Certification: To Date of Injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred After Hospital or Attending 1-Natural 5 Pending Injury 1 ☐ Yes 2 ☐ No 2 Accident investigation within 24 hours after death

To the Funeral Director:
completely filled in by the 6 Could not be determined 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 ☐ Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier (Check only one) 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 31. Date filed (Month, Day, 32. Registrar's Signature Year State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

Amend 24a per phys. G900 2/24/10 dk
State of Maryland / Department of Health and Mental Hygiene Reg. No. 20 42724 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Day Year DECEMBER 17, 2009 **Physician** 4:50 PM JAMES BERNARD SAVOY, JR. /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** La Plata Charles CIVISTA MEDICAL CENTER If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** 1 **X** M 2 □ F Months Days Hours SEPTEMBER 23, 1922 MARYLAND 213-22-2547 87 Director Usual Residence of Decedent 10b. County 10c. City, Town or Location 10d. Inside City Limits 10a State permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Important; If Item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Evaninar must be notified at once. 1 ☐ Yes 2 X No Director LA PLATA MARYLAND CHARLES 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 20646 UNITED STATES 9247 LINDY LANE Funeral 12 Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Bace - American Indian. 11. Marital Status Armed Forces?

1 Kayes 2 No 1944

If Yes, Give
Year or Dates: 1946 Black, White, etc 1 Never Married 2 Married 1 □Yes 2X No Specify: Specify: BLACK Be Completed by 3 X Widowed 4 ☐ Divorced 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) 6TH GRADE College (1-4or 5+) SUPERVISOR EXPLOSIVE TEST OPR FEDERAL GOVERNMENT 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) ELIZABETH REDYSIE PROCTOR SAVOY HURD JAMES BERNARD SAVOY, SR. ၉ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 14113 ANGELTON TERRACE, BURTONSVILLE, MARYLAND 20866 GLORIA SAVOY / DAUGHTER 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 Burial 2 ☐ Cremation 3 ☐ Removal from State ST. IGNATIUS CHURCH CEM. DEC. 22, 2009 CHAPEL POINT, MARYLAND 4 ☐ Donation 5 ☐ Other (Specify) Juliure of Funeral Service Consee THORNTON FUNERAL HOME, P.A. 3439 LIVINGSTON ROAD, INDIAN HEAD, MARYLAND 20640 LYDIA C. THORNIUN JOHNSON MO0583 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. REBRO VASCULAR Immediate Cause (Final Physician MIC disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Due to (or as a consequence of): Sequentially list conditions, Examiner ir any, leaving to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last burial-trar requires that the death certificate be execu Due to (or as a consequence of) Records, P.O. Box 68760, physician Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 23b. Was decedent pregnant 23d. Date of delivery Live birth 2 Fetal death
Pregnant at time of death 3 Ectopic pregnancy in the past 12 months? Month Year 5 Other (specify) 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part L 23e. Did tobacco use contribute to the cause of death? Completed by pul monden DIJCE & BS+ Ruchic 1 Tyes 2 No 3 Probably 4 Munknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? Yes 2 No 1 ☐ Yes 2 ☐ No of Vital 1 ☐ Yes 25. Was case referred to medical funeral director Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ∐ Yes 2 🖼 🗓 O 1 ☐ Impatient 2 ☐ ER/Outpatient 3 ☐ DOA Medical Certification: To 28a. Date of Injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Hospital or Attending Division 1 Natural 5 Pending To the Hospital or Automotive Within 24 hours after death.

To the Funeral Director: Af 1 □Yes 2 □ No 2 Accident investigation 6 Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier (Check only one) 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 44436 DECEMBER 18 2009 #304 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 50 POST OFFICERD WARDOLF MD 20602 Shvin Kumar PATIL DEC 212009 Jenus B. Sparks 31. Date filed (Month, Day, Year) 32. Registrar's Signature State

Registrar

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JAME

JR

SAVOV

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

amend #1 Pestate of Maryland Tepartment of Health and Mental Hygiene ? () () 9

1 - For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death $12^{\frac{M}{2}} - 200^{\frac{1}{2}} - 200^{\frac{1}{2}}$ **Physician** Darrell Guy Testerman 2:00 P Darrel Guy Testerman /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** ST. Mary's Hospital St. Mary's Leonardtown 8. Date of Birth (Month, Day, Year) 6-3-1943 If Under 1 Year | If Under 24 Hrs. 9. Birthplace (State or Foreign 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** Days Min. Months Hours 1 □ M 2 □ F Virginia 214-40-1622 Director Usual Residence of Decedent 10d. Inside City Limits 10b. County 10c. City, Town or Location 10a. State ortant; if item 27 is marked other than "natural", or items 23a or 28a-f show injury or other traumatic event, the Medical Examinate must be notified at 1 ☐ Yes 2√ No Directo St. Mary's Maryland Mechanicsville 10g. Citizen of What Country? 10f Zip Code 10e. Street and Number 25965 Prospect Hill Road 20659 United States Funeral 12. Was Decedent Ever in U.S.
Armed Forces?
1 Yes 2 No
If Yes, Give Year or Dates: 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 ☐ Never Married 2 🙀 Married Baltimore, Maryland 21215-0036 1 □Yes 2 No White Specify: <u></u> Specify: 3 Widowed 4 Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Building Engineer Federal Government d 2 should be filed with and Mental Hygier 7 is marked other the 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be (Lafayette G. Testerman Stella Owen 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Pages 1 and 2 st Department of Health an Important: if Item 27 is r 25965 Prospect Hill Rd., Mechanicsville, MD 20659 Brenda Testerman/Wife 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition Date December 1 Burial 2 □ Cremation 3 □ Removal from State Trinity Memorial Gardens 4 ☐ Donation 5 ☐ Other (Specify) memorial Gardens 29. 2009 Waldorf, MD 22. Name and Address of Facility Brinsfield-Echols F.H., P.A., 21. Signature of Funeral Service Licensee PO Box 128, Charlotte Hall, MD 20622 M00817 Approximate Interval Between Onset and Death 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Immediate Cause (Final Physician disease or condition resulting in death) /Medical Due to (or a a consequence of) Examiner Sequentially list conditions cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last law requires that the death certificate be executed physician and s the burial-trans Due to (or as a consequence of): P.O. Box 68760, Physician/Medical attending pl IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 □Yes 2 □ No Month Day Year ☐ Pregnant at time of death 5 ☐ Other (specify) been signed by the should be detached Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, 2 1 ☐ Yes 2 ☐ No 3 ☑ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐Yes 2 ☐ No 24a. Was an Hospital or Attending Physician: The certificate 1 ☐ Yes 25. Was case referred to medit examiner? director, 26. Place of Death (Check only one) Be Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes ≥ No 1 ☐ Inpatient 2 X ER/Outpatient 3 ☐ DOA Medical Certification: To this After th funeral 28a. Date of Injury (Month, Day, Year) 28b. Time of Injury 28c. Injury at Work? 27. Manner of Death 28d. Describe how injury occurred 1 Natural 5 Pending 1 ☐ Yes 2 ☐ No 2 Accident investigation within 24 hours after death
To the Funeral Director:
completely filled in by the 6 Could not be determined 3 ☐ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 ☐ Homicide 12 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a, Certifier (Check only one) 29c. License number 29b. Signature and title of certifier 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 0 31. Date filed (Month, Day, Year) 32. Registrar's Signature

DHMH 17 Rev 1/2001

State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Year **Physician** DECEMBER 25,2009 JOSEPH GUILIO TUONO /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner LATI-HAR CIVISTA MEDICAL CENTER If Under 1 Year | If Under 24 Hrs. 9. Birthplace (State or Foreign Country)
NEW YORK 8. Date of Birth (Month, Day, Year) 8-17-1919 5. Social Security Number 7. Age (In yrs. last birthday) Funeral 1 1 M 2 □ F Months Davs Hours 108-14-4392 90 Director Usual Residence of Decedent death with the Maryland 10b. County 10c. City, Town or Location 10d. Inside City Limits 10a State 28a-f shov 1 ☐ Yes 2√☐ No **Funeral Director** MD. CHARLES NANJEMOY 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number 11330 HOLLY SPRINGS ROAD 20662 U.S.A. 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. traumatic event, the Medical Eventinar Y☐Yes 2☐No ARMY If Yes, Give Year or Dates: WWII 1 ☐ Never Married 2 ☐ Married Baltimoré, Maryland 21215-0036 ō 1 ☐ Yes 2 🎇 No Specify: þ SpecifyWHITE 3 Widowed 4 □ Divorced "natural", Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) NAVY DEPT. Elementary/Secondary (0-12) College (1-4or 5+) nd Mental Hygiene. marked other than U.S.GOVT. CHEMIST 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be GUILIO TUONO MARY ZEMA ည 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) permit. Pages 1 and 2 Department of Health Important: If item 27 any Injury or other traonce. 11330 HOLLY SPRINGS RD. NANJEMOY, MD. 20662 LISA TUONO-DAUGHTER 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 ☐ Burial 2X Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) METROPOLITAN CREMATORY 12-29-09 ALEX., VA. 22. Name and Address of Facility MOQ479 RAYMOND FUNERAL SERVICE, P.A. LA PLATA, MD. 20646 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dyin 1, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last law requires that the death certificate be executed burial-trar Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, attending physician for use as the burial Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Day Month Year in the past 12 months? 1 ☐ Yes 2 ☐ No 4 ☐ Pregnant at time of death 5 ☐ Other (specify) cate has been signed by the page 2 should be detached 9 Unknown 23e. Did tobacco use contribute to the cause of death? ð 2 No 3 Probably 4 Unknown 1 🗌 Yes Be Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autonsy Hospital or Attending Physician: The I 24 hours after death. Funeral Director: After this certificate ha perform 1 ☐ Yes 2 ☐ No 1 ☐ Yes 25. Was case referred to medical examiner? director, 26. Place of Death (Check only one) 2 No Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 1 Department 2 ER/Outpatient 3 DOA Certification: To funeral 27. a er of Death 28b. Time of Injury 28a. Date of Injury (Month, Day, Year) 28c. Injury at Work? 28d. Describe how injury occurred 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident the 6 ☐ Could not be øetermined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 Homicide To the Hospital within 24 hours a To the Funeral D 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical completely (Check only one) and manner stated. 29d. Date signed (Month, Pay, 29c. License number 29b. Signature and title of certifier

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State 31. Date filed (Month, Day, Year)
Registrar

32. Registrar's Signature

dress of person who completed cause of death (Item 23a) (Type,

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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene 2 0 Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Day **Physician** James Nelson Townsend Рм 2009 5:04 December 23, /Medical 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Death **Examiner** St. Mary's St. Mary's Hospital Leonardtown Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** 1⊠M 2□F Months Days Hours 80 **Director** 514-22-7352 1929 May 2, Missouri Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits 28a-f show er than "natural", or items 23a or 28a-f sho Director 1 ☐ Yes 2 X No Maryland St. Mary's California 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 20619 22490 Torino Drive Funeral USA 12. Was Decedent Ever in U.S. Armed Forces? 1 ☑Yes 2 ☐ No Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian Black, White, etc. Yes 2 Yes, Give 1 ☐ Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐Yes 21 No Specify: þ White 3 Widowed 4 Divorced Ye ar or Dates: Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Pages 1 and 2 should be filed within nent of Health and Mental Hygiene. int: If item 27 is marked other than " Elementary/Secondary (0-12) College (1-4or 5+) Government Contractor Electronics Supervisor 12 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Amelia Buinger ပ Nelson Asbury Townsend 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Pages 1 and 2 and 2 and 2 and 2 and pertment of Health an Important: If item 27 is any Injury or other trauonce. Marica Townsend / Wife 22490 Torino Drive California, MD 20619 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State January 26 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 Donation 5 Dother (Specify) Arlington, Virginia Arlington National Cemetery 2009 21. Signature of Fugeral Service Uce 22. Name and Address of Facility Mattingley-Gardiner Funeral Home, P.A. P.O. Box 270 Leonardtown, MD 20650 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Immediate Cause (Final tibrillation **Physician** Ventricular disease or condition resulting in death) seconds /Medical Due to (or as a consequence of): Examiner Tschemic Sequentially list conditions, if any, leading to infinediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Hospital or Attending Physiclan: The law requires that the death certificate be executed Due to (or as a consequence of): or le and as the burial-trai Division of Vital Records, P.O. Box 68760, Physician/Medical IF FEMALE: use 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 🗆 Ectopic pregnancy for in the past 12 months? 5 Other (specify) 1 ☐Yes 2 ☐ No 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ģ Completed 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown director, page 2 should hypothyros dista 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performer certificate 1 ☐ Yes 2 ☐ No 1 ☐ Yes 2 ☐ No Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 Certification: To 1 Inpatient 2 ER/Outpatient 3 DOA after death.

Director: After this completely filled in by the funeral 27. Manner of Death Date of Injury (Month, Day, Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Natural 2 Accident 5 Pending investigation 1 ☐ Yes 2 ☐ No 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide To the Hospital within 24 hours a To the Funeral D Medical 29a. Certifier Example 12 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29b. Signature and title of certified 29c. License number 29d, Date signed (Month, Day, Year) ER Physician 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Leonalton, MD 25500 Point Losko-L 31. Date filed (Month, Day, Year) D. Tucker 00 32. Registrar's Signature State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. 1 - For Amend#5, 12/16/09, pwe FHDR., Department of Health and Mental Hygiene Registrar Certificate of Death Reg. No. Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month Year Physician Mary Pauline Turner 11, 2009 December 7:05 A /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Edenton Retirement Community Frederick Frederick If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth (Month, Day, Year) 5 Social Security Number 577-05-6748 6. Sex 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** 1 □ M 2 💢 F Director 93 Feb 14, 1916 Nebraska Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits show permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryla Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, If a Institute I is a nother traumatic event, It a Institute I is a nother traumatic. Director 1 XYes 2 No MD Frederick Frederick 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 5800 Genesis Lane 21703 USA Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☒ No Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 1 ☐ Never Married 2 ☐ Married Maryland 21215-0036 If Yes, Give Year or Dates: 1 ☐ Yes 2 ☐ XNo Specify. ģ Specify: White 3 X Widowed 4 ☐ Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) <u>Homemaker</u> Own Home 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be William C. Curtis Nellie Lee 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Daniel C. Turner/son 6905 Mink Hollow Rd. Highland, MD 20777 Baltimore, 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 ☐ Burial 2 X Cremation 3 ☐ Removal from State Final Journey Crematory 12/14/09 Woodbine, MD 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility
Going Home Cremation Service P.O. Box 784 21. Signature of Funeral Service Licenses MO1251Beverly L. Heckrotte, P.A. Clarksville, MD 21029 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on gach line. Approximate Interval Between Onset and Death Immediate Cause (Final Advan Physician MINTHS disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to [or as a conse juence of] Physician: The law requires that the death certificate be executed physician and strans Due to (or as a consequence of): Box 68760, Physician/Medical attending pl IF FEMALE: 23c. If yes, outcome of pregnancy 23b. Was decedent pregnant 23d. Date of delivery 1 Live birth 2 Fetal death 4 Pregnant at time of death 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 5 Other (specify) signed by the a P.O. 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Records, icate has been si , page 2 should t 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? Yes 2 No this certificate **Division of Vital** 1 ☐ Yes 2 🗆 No director, 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1∐Yes 2 No Certification: To 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA ieral Director: After the filled in by the funeral of 28a. Date of Injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Hospital or Attending 5 Pending investigation death. 2 Accident 1 ☐ Yes 2 ☐ No within 24 hours after deat To the Funeral Director: 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

| Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. ca 29a. Certifier completely (Check only one) 29d. Date signed (Month, Day, Year) 29b. Sig of certifier 29c. License number D006223

State Registrar 31. Date filed (Month, Day, Year)

DHMH 17 Rev 1/2001

. Name and address of person who completed cause of death (Item 23a) (Type, Print)

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32. Registrar's Signature

-09898 se Leodan Tobar	r	Please Type or Print in Black Indelible Ink. Ensure All Copie State of Maryland / Department of Health and Mental Hy	s Are Legible. ygiene
y V	R	For State Certificate of Death	Reg. No. 2009 1277 2. Date of Death 3. Time of Death
Physician/ edical Examiner	r	Jose Leodan Tobar Monge	Month Day Year 1238 hrs
	4	a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death Hyattsville	Prince George's
Funeral Director	5	Social Security Number 6. Sex 7. Age (In yrs. last birthday) If Under 1 Year If Under 24Hrs. Months Days Hours Min.	1070 Country
r any	_	sual Residence of Decedent Da. State 10b. County 10c. City, Town or Location	10d. Inside City Limits 1 X Yes 2 No
the Maryland a or 28a-f show an tified at once. Director	1	MD Prince George's Hyattsville De. Street and Number 10f. Zip Code	10g. Citizen of What Country?
th the Mi 23a or 23 notified		3558 Dean Drive #S 1 Marital Status 1 20782 1 Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Sp.	U.S.A. pecify Yes or No- 14. Race - American Indian, Black,
Baltimore, MD 21215-0036 permit. Pages I and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show injury or other traumatic event, the Mediral Examiner must be notified at once. To Be Completed by Funeral Director	1	Armed Forces? If Yes, specify Cuban, Mexican, Puerto	Rican, etc.) White, etc.
urs after tural", o aminer r	⋧┞	Widowed 4 Divorced of Pass Give Year or Dates: 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of vice in the complete of the c	work done 16b. Kind of Business/Industry
5-0036 ed within 72 hour stygiene. other than "natuthe Medical Exan		Elementary/Secondary (0-12) College (1-4 or 5+) Maintenance	Cleaning Company
5-0036 iled within 72 Hygiene. I other than the Medical	a B	9th 7. Father's Name (First, Middle, Last) 18. Mother's Name Maria J	e (First, Middle, Maiden Surname) osefina Monje na Monje
2121 rould be fil d Mental B is marked tic event,		Jose Enrique Tobar Josefia 9a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Information Address)	Rural Route Number, City or Town, State, Zip Code)
MD and 2 sho salth and 2 streem 27 is raumati		Norela Y. Turcios (Sister) 5011 S. Shesterfield Oa. Method of Disposition 20b. Place of Disposition (Name of cemetery,	Rd. Arlington, Virginia 22206 Date 20c. Location - City or Town, State
nore		Y Durist Commercian 3 Remarks from State crematory or other place)	04-2010 Washington, DC
Baftimore, permit. Pages I a Department of He Important: If ite injury or other tr		22. Name and Address of Facility W.]	H. Bacon Funeral Home, Inc. W. Washington, DC 20010.
Physician Munical xaminer	1	3. Part I. Enjer the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac of failure. List only one cause of each line. Immediate Cause (Final diseas or condition resulting in death) a. Hypertensive cardiovascular diseas or condition resulting in death) Due to (or as a consequence of): b. Sequentially list conditions,	Death
ecuted and - transit	Examine	f any, leading to immediate cause. Enter Underlying Cause Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Due to (or as a consequence of): Due to (or as a consequence of): d.	
e be exer ysician a burial -		XUNPENDED 1.8,17,18 per co g959 1-16-15 23a,1711,27, perm,E g900 2/2/10	23d. Date of delivery
ath ce	sician/i	F FEMALE: 3b. Was decedent pregnant in the past 12 months? 1 Yes 2 No 9 Unknown 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 3 Ectopic pregnant at time of death 5 Other (Specify) 9 Unknown	
hat the ded by the letached	by Phy	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.	23e. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 ✔ Unknown
cords, P.O. law requires that the has been signed by 2.2 should be detach		Chronic alcohol abuse	24a. Was an autopsy findings available prior to completion of cause of
Vital Records, hysician: The law require this certificate has been side director, page 2 should the Completers.	Completed		performed? 1 ✓ Yes 2 No 1 ✓ Yes 2 No
ician: The certificate rector, page	Be C	25. Was case referred to medical examiner? Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA Other 1 Nurs	k only one) sing Home 5 Residence 6 ✔ Other Scene
of Vii ng Physic After this uneral dir	입	1 ✓ Yes 2 No Injury 28b. Time of Injury 28c. Injury at Work?	28d. Describe how injury occurred
Division fal or Attendi rs after death. at Director: A led in by the fi	Certification:	X Natural 5 Pending Investigation 2 Accident 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc.	28f. Location (Street and Number or Rural Route Number, City or Town, State)
Division of To the Hospital or Attending Phwitin 24 hours after death. To the Funeral Director: After completely filled in by the funeral condition of certification: T		4 Homicide determined (Specify) 29a. Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and	nd due to the cause(s) and manner as stated.
To the lawithin 2	잃	(Check only one) 2 Medical Examiner:On the basis of examination and/or investigation, in my opinion, death occurred and manner stated. 29b. Signature and title of certifier 29c. License number	d at the time, date and place, and due to the cause(s) 29d. Date signed (Month, Day, Year)
		250. Signature and the or continu	December 21, 2009
	-	faind O.C.M.E.	
2 3		Russell Alexander MD. Assistant Medical Examiner 111 Penn Street, Baltimore, N	

State of Maryland / Department of Health and Mental Hygiene Certificate of Death For State Registrar AMENC#20bperFH, 12/22/09, EMW, McCo Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician 12, 4:00 pm Wai. Tse 2009 December /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death **Examiner** Rockville Shady Grove Adventist Hospital Montgomery If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 02/01/1919 Birthplace (State or Foreign Country) 5. Social Security Number 6. Sex 7. Age (In yrs, last birthday) **Funeral** 1**⊠** M 2□ F Months Days Hours Min. China 90 Director 220-86-3991 Usual Residence of Decedent Pages 1 and 2 should be filed within 72 hours after death with the Maryland nent of Health and Mental Hygiene.
int: If Item 27 Is marked other than "natural", or items 23a or 28a-f show 10a, State 10b. County 10c. City, Town or Location 10d. Inside City Limits "natural", or items 23a or 28a-f show adieal Examinar must be notified at 1 □Yes 217 No Maryland Baltimore Randallstown Direct 10e. Street and Number 10g. Citizen of What Country? 8810 Church Lane 21133 U.S.A. Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ∐Yes ≥ 2 XI No If Yes, Give Ye ar or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 11. Marital Status 1 ☐ Never Married 2 X Married Baltimore, Maryland 21215-0036 þ 1 ☐ Yes 2 🗶 No Specify: Specify: 3 Widowed 4 Divorced Asian Completed 16a. Decedent's Usual Occupation 16h Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) 6 Cook Food Service 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Yuen Chun Tse 27 Is marke traumatic Yiu Cheung ျှ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Hawyee Yan - Daughter 12308 Pissaro Drive, N. Potomac, Maryland 20878 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State permit. Pages
Department of
Important: If it
any injury or o 12/19/2009 | Silver Spring, MD 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Gate of Heaven Cem. 22. Name and Address of Facility Hines-Rinaldi Funeral Home, Inc. 21. Signature of Funeral Service Licensee |11800 New Hampshire Ave., Silver Spring, MD 20904 23. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, of heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** Pulmonary Cardiac Arrest /Medical Due to (or as a consequence of): Examiner Acute Renal Failure Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examine Due to (or as a consequence of, sician and burial-trans Respiratory Failure Due to (or as a consequence of) Division of Vital Records, P.O. Box 68760, attending physician for use as the buria Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month 5 ☐ Other (specify) detached 9 Unknown certificate has been signed by rector, page 2 should be detach Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 ☐ Yes 2 1 No 3 ☐ Probably 4 ☐ Unknown Be Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an performed' 1 ☐ Yes 2 ☐ No 1 ∐Yes 2 🛛 No 25. Was case referred to medical 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 ☑ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 1 Tes 2 No Certification: To 28a. Date of Injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 1 X Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 ☐ Accident 6 ☐ Could not be 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide To the Hospital o within 24 hours af To the Funeral Di 1 💢 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier P0065505 m.D. 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) MEDICAL CENTER DR. ROCKVILLE, MD. 9901 M. D. QIUFANG CHENG 31. Date filed (Month, Day, Year) 2. Registrar's Signature State DEC 17 2009 Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene ForAmend Item 26 State of Maryland Astate Registrar WCHD/SH 12/29/09 per DR/NP Certificate of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ 1310 Decem 2009 Raymond Lewis Taylor Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Washington County Hospital Hagerstown Washington Social Security Number Age (In vrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** 1 🕅 M 2 🗆 F Months Hours JaH^{on}30^{ay, Y}1945 Maryland 64 **Director** 217-42-9008 Usual Residence of Decedent 28a-f shov permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director 1 XYes 2 No Maryland Washington Williamsport 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 205 Grove Avenue 21795 USA Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 11. Marital Status 14. Race - American Indian Armed Force Black, White, etc. þ 1 Never Married 2XXMarried 2 X No Yes Baltimore, Maryland 21215-0036 1 ☐ Yes 2X No Specify: If Yes, Give Completed 3 Widowed 4 Divorced Year or Dates White 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) 12 Correctional Officer Government Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ည Howard Reichard Taylor Margaret Irene Houser 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 21795 Judith E. Taylor -Wife 205 Grove Avenue Williamsport, Maryland 20a. Method of Disposition

1 → Burial 2 ☐ Cremation 3 ☐ Removal from State 20b. Place of Disposition (Name of Date 20c. Location - City or Town, State cemetery, crematory or other place) Bonation 5 Other (Specify) Dec. 23, 2009 | Hagerstown, Maryland Rose Hill Cemetery anature f Funeral S Osborne Funerally Home, P.A. Conococheague St. Williamsport, MD 21795 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Betwee shock, or heart failure. List only one cause Onset and Death Immediate Cause (Final Ph sician/ disease or condition resulting in death) Medical Examiner Due o (or as a conseque ce of): Sequentially list conditions Examiner if any, leading to immediate cause. Enter Underlying ending physician and use as the burial-transit Hospital or Attending Physician: The law equires that the death certificate be executed Cause (Disease or linjury that initiated events resulting in death) Last Due to (or as a consequence of): signed by the attending physician Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery Ectopic pregnancy in the past 12 months?
1 Yes 2 No Month Year Day Pregnant at time of death Other (specify) Yes 1 Yes 2 L 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 3 ☐ Probably 4 ☑ Unknown Completed 1 Yes 2 No een 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an after death.

Director: After this certificate has t autopsy perform 1 ☐ Yes 2 ☐ No Yes 2 25. Was case referred to medical examiner?

1 Yes 2 No Be funeral director, 26. Place of Death (Check only one) Hospital Other: 1 ☐ Inpatient 2 🖁 ER/Outpatient 3 ☐ DOA မ 4 Nursing Home 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at work?
1 Yes Certificate: 28d. Describe how injury occurred injury Natural 5 Pending 2 Accident
3 Suic 2 No Investigation Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined 24 hours a Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check within 2 To the F only one) 29b. Signature and title of certifier

State

Registrar
DHMH 17 Rev 7/2009

30. Name and address of person who completed

filed (Month, Day, Year)

DEC 2

cause of death (Item 23a) (Type, Print)

strar's Signature

	_	For State Registrar	State of Maryla	•	tificate of		F	Reg. No.	2009	42732	
Physicia		1. Decedent's Name (First, Middle, Lass Lawrence Jose					2. Date of Dea Month Decemb		3, 2009	8:16 a M	
/Medica Examine		4a. Facility Name (If not institution, give Carroll Hospital	e street and number)		* .	r Location of Death			County of Death		
Funeral Director		221-60-3033	ex 7. Age (<i>In yrs</i> 48	s. last birthday) Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day Feb 8,	7, Year) 1961	Cou	place (State or Foreign ntry) achusetts	
Maryland a-f show iffied at	ctor	Usual Residence of Decedent 10a. State 10b. County Maryland Carrol		City, Town or Loc		stminste		10d. Inside City Limits 1 □Yes 2 No			
th with the 23a or 28	al Dire	10e. Street and Number 341 Old Bachmans V	Valley Road		10f. Zip Code	21157		10g. Citize	en of What Cou	ntry?	
Baltimore, Maryland 21215-0036 permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 23a-f show any Injury or other traumatic event, the Medical Examinat must be notified at once.	Completed by Funeral Director	11. Marital Status 1 Never Married 2 Married 3 Widowed 4 Divorced	1 □Yes 2 X No		Was Decedent of Hispanic Origin? (Specify Yes or f Yes, specify Cuban, Mexican, Puerto Rican, etc.) t □ Yes 2 M No Specify:			14. Race - American Indian, Black, White, etc. Specify: white			
Baltimore, Maryland 21215-0036 permit. Pages 1 and 2 should be filed within 72 hours att Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or any Injury or other traumatic event, the Medical Eventuae.	ompleted	15. Decedent's Ed (Specify only highest gra Elementary/Secondary (0-12)	ucation de completed) College (1-4or 5+)	I (Give k	ent's Usual Occup aind of work done O NOT use retired Salesma	king	16b. Kind of Business/Industry		dustry		
land 2 labe filed Aental Hygirked other tic event, I	To Be C	17. Father's Name (First, Middle, Last) William W. Terro				18. Mother's Nan	ne (First, Middle, ara Ann				
and 2 shot ealth and N n 27 is ma		19a. Informant's Name/Relationship (*Cindy Lou Terroy,		19b. Mailing Address (Street and Number or Rural Route Number, City or Town, St. 5101 South Rolling Road, Halethorpe,							
imore, Pages 1 anent of He		20a. Method of Disposition 1 ☐ Burial 2 🌠 Cremation 3 ☐ 4 ☐ Donation 5 ☐ Other (Specify			ition (Name of atory or other place Cremator		Date 6/2009		ation - City or To		
Baltimc permit. Page Department of Important: If any Injury or once.		21. Signature of Funeral Service Licen	Surpriau	_1	Name and Addre	ss of Facility M Street,	yers-Dur Westmir	bora ster	w Funer , MD 21	al Home 157	
Physician	\	23a. Part 1 Enter the disease, or com shock, or heart failure. List only Immediate Cause (Final disease or condition	^				or respiratory ar	rest,		Approximate Interval Between Onset and Death	
/Medical Examiner		resulting in death)	Due to (or as a conse	equence of): Atter	farction Disease	P					
cuted nd ransit	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events	Due to (or as a conse	equence of):	1						
	ledical Ex	resulting in death) Last	Due to (or as a conse	equence of):							
Box (eath certi attending for use a	Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown 23c. If yes, outcome of pregnancy 1 □ Live birth 2 □ Fetal death 4 □ Pregnant at time of death 5 □ Other (specify) □ □ Unknown							23d. Date of delivery Month Day Year		
cords, P.O. w requires that the d been signed by the should be detached	by Pr	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobac End-Stage Renel Disease							cco use contribute to the cause of death? 2 MNo 3 □ Probably 4 □ Unknown		
Division of Vital Records, for Attending Physician: The law requires the after death. Director: After this certificate has been signed in by the funeral director, page 2 should be death.	Completed by	Atrial Fibrillation					24a. Was autop perfor 1 □Yes	sv	24b. Were aut prior to codeath?	opsy findings available ompletion of cause of	
Vita	Be	25. Was case referred to medical examiner? 1 ☐ Yes 2 M No	Hospital: 1 ☐ Inpatient 2	Med EDIO	Oth	er.	ath (Check only o	ne)	D04 (0	· · ·	
Division of Vital Rec To the Hospital or Attending Physician: The law within 24 hours after death. To the Funeral Director: After this certificate has completely filled in by the funeral director, page 2:	Certification: To	27. Manner of Death 1 Natural 5 Pending 2 Accident investigation	28a. Date of Injury (Month, Day, Year)	28b. Time of	28c. Injui Wor		lome 5 Resid			пу)	
Divisi	Sertifica	3 Suicide 6 Could not be determined	28e. Place of Injury - At building, etc. (Spec	home, farm, stre	et, factory, office				Street and Number or Rural Route Number, wn, State)		
ne Hospit 124 hour: ne Funera	Medical		ysician: To the best of my k niner: On the basis of exami and manner stated.								
To the Company of the	Me	29b. Signature and title of certifier			29c. Licens	se number			signed (Month		
2		30. Name and address of person who	completed cause of death (It	em 23a) (Type, F			1220				
Stat		31. Date filed (Month, Day, Year)	completed cause of death (Its GOL Loch Esce 32. Registrar's Sign 1009 Jenus	nature	Da Hillion	2 140 2	1624				
Registra		DEC 16 2	009 Seneva	B. A	arke						

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ December Kevin McGuire White 40a M Medical 4a. Facility Name (if not institution, give street and number)
Doctor's Community Hospital **Examiner** 4b. City, Town, or Location of Death 4c. County of Death Lanham Prince George's 5. Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** 224-06-6962 Months Hours Dec. 16, 1957 1 🕅 M 2 🗆 F 52 Washington, DC Director Usual Residence of Decedent permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hyglene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at any injury or other traumatic event, the Medical Examiner must be notified at 10c. City, Town or Location Greenbelt 10b. County 10d. Inside City Limits Director Maryland Prince George's 1 X Yes 2 □ No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 73 Q Ridge Road 20770 United States 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Armed Forces?

1 Yes 2 X No Black, White, etc. ğ 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify: White If Yes, Give Year or Dates Specify 3 Widowed 4 Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) Retail Management Private Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) 2 Robert E. White Mary Anne Cahill 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Saira White -wife 73 O Ridge Road Greenbelt, Maryland 20770 20a. Method of Disposition 20b. Place of Disposition (Name of Date 20c. Location - City or Town, State St. Mary's Cemetery 12/29/2009 1X Burial 2 Cremation 3 Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Alexandria, Virginia 21. Signafure of Funeral Service Lice Bonaid V. Borgwardt Funeral Home, 4400 Powder Mill Road Beltsville, On Maryland 20705 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final Onset and Death Physician. disease or condition Medical resulting in death) Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or linjury that initiated events resulting in death) Last Examine Due to (or as a consequence of) Hospital or Attending Physician: The law requires that the death certificate be executed Due to (or as a consequence of) Physician/Medical Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death
4 Pregnant at time of death
9 Unknown 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy
5 Other (specify) in the past 12 months?

1 Yes 2 No Month Year Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed 1 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy perform certificate Yes Division of Vital 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? 2**X** No ဂ္ 1 Tes Other: 1 Inpatient 2 ER/Outpatient 3 IDOA 4 Nursing Home 5 Residence 6 Other (Specify) funeral 28a. Date of injury (Month, Day, Year) 27. Manner of Death Certificate: 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 Natural 5 Pending work Accident 1 🗌 Yes 2 🗌 No Investigation Suicide 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined within 24 hours after
To the Funeral Directory Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated only one) 3 ... Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Registrar DHMH 17 Rev 7/2009

5

State

29b. Signature and title of certifier

31. Date filed (Month, Day, Year)

30 Name and address of person who completed cause of death (Item 23a) (Type, Print

32. Registrar's Signature

29d. Date signed (Month, Day, Year)

20706

	-	For State Registrar		St	ate of N	Marylan	d / Depa	artment of I	Health and M Death	Mental Hy	giene Reg. No. 2	009	42734
Physiciar		Decedent's Name (i	First, Middle,	Last)			Webbe			2. Date of Dea December	ith	2009	3. Time of Death 4:05 pm M
Medica Examine		4a. Facility Name (if no Northamp					ter	4b. City, Town, or Freder:	r Location of Death		4c. Cou	unty of Death	
Funeral Director		5. Social Security Num 054-07-50 Usual Residence of De	067	6. Sex 1 □ X M 2	2 □ F 7. F	Age (In yrs. Ia		If Under 1 Year Months Days	1f Under 24 Hrs. Hours Min.	8. Date of Birtl (Month, Day Dec 04	1914	9. Birth Cour N ew	place (State or Foreign http:// York
faryland 3a-f show tified at	ector		10b. County Frede	erick		10c. City	Town or Loc Monr						10d. Inside City Limits 1 ☐ Yes 2 🔀 No
with the N 23a or 28 ust be not	Funeral Director	10e. Street and Numb 3842 Chau		ourt				10f. Zip Code	21770		10g. Citizen	of What Cour S.A.	ntry?
fter c	ρ	11. Marital Status 1 ☐ Never Married 3 🛣 Widowed 4		ed 1	as Deceden med Forces X Yes 2 (Yes, Give ar or Dates.		4 -	Vas Decedent of H f Yes, specify Cuba	ispanic Origin? (Sp nn, Mexican, Puerto Specify:	ecify Yes or No- Rican, etc.)		Race - Americ Black, White, cify: Wh	
within 72 hou rgiene. ner than "nat ner the Medica	• Completed		15. Decedent fy only highes day (0-12)	t grade con		r 5+)	(Give I	lent's Usual Occup kind of work done o O NOT use retired) K WORKER	ation during most of work	king		of Business In	_{dustry} Factory
ld be filed Mental Hy iarked ott atic even	To Be	17. Father's Name (Fin	st, Middle, La Inthony			Webber	:		18. Mother's Nam Margar			^{ame)} cker	
nd 2 shou ealth and m 27 is m ner traum		Robert Si	lverma				3842	Chaucer	Court, M	al Route Number Ionrovia	, City or Tow , Mary	n, State, Zip (land 2	^{Code)} 21770
Page 1 a ment of H tant: If ite ury or oth		20a. Method of Dispos 1 Denrial 2 X 4 Donation 5	Cremation		val from Sta	L CE	emeterv. cren	sition (Name of natory or other place g Cremat	ce) i	Date 30, 2009		on - City or To thsbur	own, State g, Maryland
permit. Depart Import any inj		21. Signatur of Funer	ral Service (id	Sevse	سس	M007	706 10	Keeneyde 06 East (Basford Church St	l P.A. Fu , Freder	uneral rick,	. Home Maryla	and 21701
Ph __ sician/		23a. Pair 1. Enter the shock, or heart f Immediate Cause (Fir disease or condition	failure. List on	omplication ly one caus	ns that caus se on each li	ne.	Do not ente		g, such as cardiac	or respiratory arre	est,		Approximate Interval Between Onset and Death
) Medical Examiner	_	resulting in death) Sequentially list cond	litions	a. —	Due to (or a	s a consequ	ence of):						
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ite be executed hysician and he burial-transit	dical E	resulting in death) Last Due to (or as a consequence of): d											
To the Hospital or Attending Physician: The law requires that the death certificate by within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physic completed filled in by the funeral director, page 2 should be detached for use as the b		PIF FEMALE: 23b. Was decedent properties in the past 12 mo 1 ☐ Yes 2 ☐ I 9 ☐ Unknown	onths?	1 4	Live Birth	at time of de	death 3	Ectopic pregnand Other (specify)	÷у		23d.	Date of deliv Month	ery Day Year
ires that the signed by		Part II. Other significa	ant condition		ing to death	but not resu	ilting in the u	nderlying cause giv	ven in Part I.				he cause of death?
e has beer age 2 shoul	Completed by	//								24a. Was a autop	sy med?	prior to co death?	psy findings available impletion of cause of
rsician: The law scertificate has be lirector, page 2 s	To Be C	25. Was case referred examiner?	/	Hospita	ll;	stiont 2 1	ER/Outpatien	Othe	ace of Death (Chec		•		2 No
rth. : After this e funeral c		27. Manner of Death 1 Natural 2 Accident	5 Pending		a. Date of in (Month, D	jury	28b. Time of injury	28c. Injury work	/ at	ome 5 Resid			
al or Atters as after des	Certificate:	3 ☐ Suicide (4 ☐ Homicide	6 Could no determin		e. Place of Ir building, e	njury - At hor etc. (Specify)	me, farm, stre	eet, factory, office		28f. Location (Si City or Town		mber or Rurai	l Route Number,
he Hospit in 24 hour he Funera pleted fille	Medical	(Check 2 L	Medical Ex	aminer: On	the basis of	examination	and/or invest	igation, in my opinio	, date and place, ar on, death occurred a e time, date and place	it the time, date ar	nd place, and	due to the ca	use(s) and manner stated.
To t Con		29b. Signature and title	e of certifier	,	MD	v.		29c. License	number 5546	36	29d. Date sig	gned (Month,	Day, Year) 9
3		30. Name and address	HAQ	ho complet	ed cause of	death (Item	3 1	aire A	ve Fr	cderi	CK. Y	MD	21701
State Registra		31. Date filed (Month, I	Day, Year) 2010	he	32. Regis	trar's Signatu	ire	,					
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DHMH 17 Rev 7/2009

Baltimore, Maryland 21215-0036

Division of Vital Records, P.O. Box 68760

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. Amend Items 23a,25 per me, g899,01/06/10dhb Certificate of Death Reg. No. 1 - For State Registrar Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 1 Month Physician/ Wilt Jefferv Dale Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** 4c. County of Death Western Maryland Regional Medical Ctr. Cumberland Allegany 5. Social Security Number 7. Age (In vrs. last birthday) If Under 1 Year If Under 24 Hrs. 9. Birthplace (State or Foreign Country) Funeral 8. Date of Birth 1 □ M 2 □ F Jul 16, 1967 Days 162-60-7658 Director 42 Usual Residence of Decedent 28a-f shov 10a. State 10b. County 10c. City, Town or Location Page 1 and 2 should be filed within 72 hours after death with the Maryland ment of Health and Mental Hygiene. and I fleath and Mental Hygiene. and I fleath and Saa or 28a-f sho and I fleath and 17 is marked other than "natural", or items 23a or 28a-f sho ury or other traumatic event, the Medical Examiner must be notified at ury or other traumatic event, the Medical Examiner must be notified at 10d. Inside City Limits Director MD Allegany Cumberland 1 XYes 2 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 14014 Cedarwood Drive, SW 21502 USA 12. Was Decedent Ever in U.S. 11. Marital Status Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Armed Forces?

1 Yes 2 No
If Yes, Give
Year or Dates. Black, White, etc. þ 1 Never Married 2 Married Maryland 21215-0036 1 Yes 2 No Specify: 3 Divorced 4 Divorced Specify Completed white 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) n/a n/a Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ပ Dewey Wilt JoAnn Wilt 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code, P.O. Box 20 Markleton PA Terry Wilt brother 15551 PA Baltimore, 20b. Place of Disposition (Name of cemetery, crematory or other place)
Scarpelli Funeral Home, P.A. 20a. Method of Disposition Date 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Memation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Department of Important: If it any injury or c 12/14/2009 MD Cresaptown 21. Signature of Fune I Service Ucenses 22. Name and Address of Fernit Fernit Home, PA 108 Virginia Avenue: Cumberland, MD 21502 23a. Part / Enter the disease or simplications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart finitire. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Physician/ Medical **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury that initiated events Examine Due to (or as a consequence of) the attending physician and thed for use as the bunal-transit CERTIFICATION A resulting in death) Last Due to (or as a consequence of): Physician/Medical #23apナル すめかり IF FEMALE: To the Funeral Director: After this certificate has been signed by the attendin completed filled in by the funeral director, page 2 should be detached for use: 23c. If yes, outcome of pregnancy

1 Live Birth 2 Fetal death
4 Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery in the past 12 months?

1 Yes 2 No 3 Ectopic pregnancy Month 5 Other (specify) Day Year 9 Unknown 9 Unknown Part II. Other significarit conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Certificate: To Be Completed by 1 ☐ Yes 2 🖢 No 3 ☐ Probably 4 ☐ Unknown Sigmoid volvulus with complications 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an performed? Yes 2 No 1 Yes 2 No 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Hospital Other: 2 1 No 1 npatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify, 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred work?
1 Yes 2 No Natural 5 Pending injury 2 Accident
3 Suicide Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined To the Hospital or within 24 hours aff To the Funeral Dir Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner So the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place and the time date and place. Medical 29a. Certifier (Check Examiner on the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated by Wurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one) 29b. Signature and title of ce 29c. License number 29d. Date signed (Month, Day, Year) 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) JUAN ARRISUENO, 902 SETON DR. SUITE 205 CUMBERLAND, MD 21502 MD

DHMH 17 Rev 7/2009

State Registrar 31. Date filed (Month, Day, Year)

32. Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Decedent's Name (First, Middle, Last) 2 Date of Death Physician/ ROBERT E. WILLISON Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner ALLEGANY WESTERN MD REGIONAL HOSPITAL CENTER CUMBERLAND 9. Birthplace (State or Foreign If Under 1 Year If Under 24 Hrs. 8. Date of Birth Social Security Number 7. Age (In yrs. last birthday) Funeral Days (Month, Day, Year) 1 07 1936 Country)
MARYLAND Director 214-34-1668 Usual Residence of Decedent should be filed within 72 hours after death with the Maryland and Mental Hygiene. 10a, State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director ms 23a or 28a-f s must be notified 1 🗌 Yes 2 🕱 No FROSTBURG MD ALLEGANY 10e. Street and Number 10f, Zip Code 10g. Citizen of What Country? Funeral 17113 CARSCADEN RD SW 21532 U.S.A. items 12. Was Decedent Ever in U.S. Armed Forces?

1 Yes 2 No If Yes, Give 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Examiner Black, White, etc. 9 1 Never Married 2 Married Completed by Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify: Specify: "natural", 3 Widowed 4 Divorced WHITE Year or Dates ed other than "nature event, the Medical 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) College (1-4 or 5+) Elementary/Seconday (0-12) ROOFER SHEET METAL ROOFING marked other Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ပ TOOTS WILLISON EDITH (BELTZ) WILLISON 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) <u>s</u> permit. Page 1 and 2 sh Department of Health ar Important: If item 27 is any injury or other trau once. BEATRICE WILLISON WIFE 17113 CARSCADEN RD SW FROSTBURG, MD 21532 20a, Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 1 Burial 2 Cremation 3 Removal from State 4 ☐ Donation 5 ☐ Other (Specify) CUMBERLAND CREMATORY 12-23-09 CUMBERLAND, MD 21. Signature of Funeral Service Licensee 22. Name and Address of Facility SOWERS FUNERAL HOME, FROSTBURG, MD 21532 Sowers MO0 547 60 W. MAIN ST 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Immediate Cause (Final Onset and Death WIDESPREAD LUNG CANCER Ph sician/ Medical resulting in death) Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examine Due to (or as a consequence of) Cause (Disease or linjury that initiated events resulting in death) Last attending physician and Due to (or as a consequence of): Physician/Medical Division of Vital Records, P.O. Box 68760 the IF FEMALE: use 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregna 5 Other (specify) Ectopic pregnancy in the past 12 months? Day Month Year Pregnant at time of death Unknown g 🗌 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ (IND STAGE RENM FAILURE 1 Yes 2 □ No 3 □ Probably 4 □ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? END STAGE CARRONIC ORSTRUCTIVE PULMONANT DISTAS 24a. Was an autopsy performe this certificate 2 500 1 🗌 Yes 2 X N ☐ Yes To the Hospital or Attending Physician: 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 No 1 Yes မ 1 Ninpatient 2 ER/Outpatient 3 DOA completed filled in by the funeral 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred : After t 5 Pending after death. 1 ☐ Yes 2 ☐ No Accident Suicide Investigation 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide City or Town, State) 24 hours Medical 1 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated within 2 To the I 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) accompon 21,

Registrar

State

31. Date filed (Month, Day, Year)

JAN 0 7 2010

1063

32. Registrar's Signatur

NATIONAL MIGINAY LAVACE

MARYCAND

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

M. 22

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 2009

			For State of State of Registrar	Cei	rtificate of D		entai mygie Reg.		76101	
			Decedent's Name (First, Middle, Last)				2. Date of Death		3. Time of Death	
	Physicia Medic		Albert Neal Wan	d_			Month December	24, 2009	10:25 p ^M	
-	Examin		4a. Facility Name (if not institution, give street and numb	er)	4b. City, Town, or L	ocation of Death		4c. County of Death	•	
5			St. Mary's Nursing Co			nardtown St. More If Under 24 Hrs. 18. Date of Birth 9. Birth				
	Funeral Director		5. Social Security Number 6. Sex 1. ★ 2 □ F 7	. Age (In yrs. last birthday) 79 Yrs.	Months Days	Hours Min.	8. Date of Birth (Month, Day, Yes April 28	9. Birth	place (State or Foreign ntry) Maine	
			Usual Residence of Decedent				APILL 20	,1000	Harne	
	yland f sho ed at	ctor	10a. State 10b. County	10c. City, Town or Lo	cation				10d. Inside City Limits	
	e Mar r 28a- notifi	Sire	Maryland St. Mary's 10e. Street and Number	Leonar					1 ☐ Yes 21€No	
	ith th	ral			10f. Zip Code 20650		10g.	Citizen of What Cou USA	ntry?	
	ems	Funeral Director	21585 Peabody Street 11. Marital Status 12. Was Deced	ent Ever in U.S. 13.1			ify Yes or No-	14. Race - Americ	can Indian.	
21215-0036	1 and 2 should be filed within 72 hours after death with the Maryland if Heath and Mental Hygiene. Item 27 is marked other than "natural", or items 23a or 28a-f show other traumatic event, the Medical Examiner must be notified at	Completed by F	1 ☑ Never Married 2 ☐ Married 1 ☐ Yes 2 ☐ If Yes, Give Year, or Date	2 XX No	Was Decedent of His If Yes, specify Cuban 1 ☐ Yes 2xxxxNo		ićan, etc.)	Black, White,		
2-0	2 hou "natu	plet	15. Decedent's Education (Specify only highest grade completed)		dent's Usual Occupat		168	o. Kind of Business In	dustry	
121	thin 72 ne. than	mo;	Elementary/Seconday (0-12) College (1-4	or 5+) life. D	O NOT use retired)			Archdioces		
25	filed within al Hygiene.	ادها	17. Father's Name (First, Middle, Last)	<u> Cat</u>	holic Pri	est 18. Mother's Name		Washington	<u>L</u>	
au	lld be file Mental I arked c atic eve	일	Albert Neal Ward			Alice	Marguer:	•	137	
Maryland	should be and Ment is marker raumatic e		19a. Informant's Name/Relationship (Type, Print)	19b. Mailir	ng Address (Street an			y or Town, State, Zip		
	nd 2 sl salth s n 27 i		Robert H. Moreland/ PR		Box 249,				ŕ	
Baltimore,			20a. Method of Disposition 1 X Burial 2 □ Cremation 3 □ Removal from S	20b. Place of Dispo	sition (Name of matory or other place)) Di	ate 200	c. Location - City or To	own, State	
ij	nit. Page 1 artment of I ortant: If it injury or of		4 ☐ Donation 5 ☐ Other (Specify)	Gate of I	Heaven	12/29	/2009 Si	lver Spri	ng, MD	
Bal	permit. Page Department of Important: If any injury or once.		21. Signature of Funeral Service Licensee Edward N. Brinsfield.					uneral Hordtown, MD		
			23a. Part 1. Enter the disease, or complications that ca shock, or heart failure. List only one cause on each	line				,	Approximate Interval Between	
	nysician/ ⊢Medical		Immediate Cause (Final disease or condition resulting in death)		Jail.	ander	usenla	des	Onset and Death	
1	Examiner		Die 10 (or	as a consequence of):				8		
		ner	9 squartially list or ditions, if any, leading to immediate cause. Enter Underlying	as a consequence of):						
	uted id ansit	Examiner	cause. Enter Underlying Cause (Disease or iinjury that initiated events c							
	e execian ar	Ē	resulting in death) Last Due to (or	as a consequence of):						
3760	death certificate be executed he attending physician and ed for use as the burial-transi	Physician/Medical	d							
687	ertifica ding p	/Me	IF FEMALE: 23c. If yes, outcome	ome of pregnancy						
Box 68	ath o atten for us	ciar	in the past 12 months?	rth 2 ☐ Fetaldeath 3 🛭	Ectopic pregnancy Other (specify)			23d. Date of deliv Month	ery Day Year	
B	the de by the ached	hysi	g Unknown 9 Unkno							
P.O.	that gned k	by P	Part II. Other significant conditions contributing to dea	th but not resulting in the u	ınderlying cause give	n in Part I.	23e. Did tobaco	co use contribute to the	he cause of death?	
ds,	quires	ted					1 🗆 Yes	2 No 3 ☐ Pro	bably 4 🗆 Unknown	
Division of Vital Records,	The law requires that the death certificate be executed rate has been signed by the attending physician and page 2 should be detached for use as the burial-transit	Completed					24a. Was an autopsy	prior to co	psy findings available empletion of cause of	
<u>m</u>	The ate		25. Was case referred to medical				performed	No 1 Yes	2 X No	
/ita	siciar s certii lirecto	o Be	examiner?	patient 2 ER/Outpatier	Othor	e of Death (Check		П он то то		
of/	g Phy er this ieral c	:e: To	27. Manner of Death 28a. Date of	injury 28b. Time of	28c. Injury a	7	Bd. Describe how in	e 6 ☐ Other (Specif) njury occurred	2	
ou	endin sath. or: Aft he fur	ficat	2 Accident Investigation	Day, Year) injury	M 1 □ Y	es 2 🗆 No				
visi	or Att	Certificate:		f Injury - At home, farm, stre , etc. <i>(Specify)</i>	eet, factory, office	2	8f. Location (Street City or Town, St	and Number or Rura ate)	Route Number,	
Ö	pital o		29a. Certifier 1. Certifying Physician: To the bes			tota and place, and	d	\ d		
	To the Hospital or Attending Physiciam: within 24 hours after death. To the Funeral Director, After this certifical completed filled in by the funeral director,	Medical	29a. Certifier (Check 2 Medical Examiner: On the best only one) 3 Certifying Nurse Practioner: To	of examination and/or invest	tigation, in my opinion,	, death occurred at t	he time, date and pla	ace, and due to the ca	use(s) and manner stated.	
	To th within To th comp	<	29b. Signature and title of certifier	/	29c. License r			Date signed (Month,		
	.0		· Vn Im	tun	1/4	1285	/	2-79-	09	
0	Deme		30. Name and address of person who completed cause	of death (Item 23a) (Type, P	Print)					
9	Cul		William Boyd, II, M.D. 31. Date filed (Month, Day, Year) 32. Rem	25365 Poin	t Lookout	Rd., Leo	nardtown,	MD 20650		
	Stat Registra		DEC 2 9 2009		ake					

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. Amend Items State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. for State Registrar Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Month Day Year 2141AM Com Zon 2009 Medical Facility Name (if not institution, give street and number **Examiner** Town, or Location of Death County of Death DURNIE 8. Date of Birth (Month, Day, Yea January 29, If Under 1 Year If Under 24 Hrs. 9. Birthplace (State or Foreign Country) Washington, DC **Funeral** Security Number Age (In vrs. last birthday) Days 1 X M 2 F Months Min. 577-20-2552 87 Yrs. Director Usual Residence of Decedent or 28a-f shov notified at 10a. State 10b. County with the Maryland 10c. City, Town or Location 10d. Inside City Limits Director Maryland 1 X Yes 2 No Anne Arundel Severna Park 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? ral", or items 23a or Examiner must be Funeral 725 Cottonwood Drive USA 21146 death 11. Marital Status 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Armed Forces? Black, White, etc. should be filed within 72 hours after and Mental Hygiene.
is marked other than "natural", or þ 1 Never Married 2 Married If Yes, Give Year or Dates. WWII 1 ☐ Yes 2 X No Specify. Maryland 21215-003 Specify: White Completed 3 X Widowed 4 Divorced the Medical 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) Department of Navy 12 Computer Programmer Be traumatic event, 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) မ Earl Wood Loretta Van Cise 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Page 1 and 2 sh Department of Health ar Important: If item 27 is any injury or other trau Marilyn Clements / Daughter 725 Cottonwood Drive, Severna Park, MD 21146 Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Page 1 1 \boxtimes Burial 2 \square Cremation 3 \square Removal from State Arlington National Cemetery 1/6/2010 4 ☐ Donation 5 ☐ Other (Specify) Arlington, Virginia Signature of Funeral Service Licensee 22. Name and Address of Facility 4739 Baltimore Avenue FAN Rex, ens Gasch's Funeral Home, P.A. Hyattsville, MD 20781 Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ ACUITE MAYOCARDIM IN FALCOON disease or condition Medical resulting in death) Due to (or as a consequence of) Examiner FEMULA ME RA CTUNE 05 Sequentially list conditions, Examine ii any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury that initiated events Due to (or as a consequence of). ON APPROVED BY MEDICAL EXAMINER Ri GNT Munumy To the Hospital or Attending Physician: The law requires that the death certificate be executed burial-transit attending physician and for use as the burial-tran CERTIFICAT Due to (or as a consequence of) resulting in death) Last Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy 5 Other (specify) ____ signed by the atte in the past 12 months?
1 ☐ Yes 2 ☐ No Day Year Pregnant at time of death g 🔲 Unknown g 🗌 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Completed 1 Yes 2 No 3 Probably 4 Unknown page 2 should been s 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has autopsy performed? Yes 2 No After this certificate 1 ☐ Yes 2 ☐ No nours after death.

neral Director, After this certificated in by the funeral director, ps. 25. Was case referred medical Be 26. Place of Death (Check only one) Hospital: 1X Yes 2 1 No Other: 잍 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) 27. Man or of Death Certificate: 28a. Date of injury 28b. Time of 28c. Injury at 28d. Describe how injury occurred tural 5 Pending injury X Accident Subject fell. 12/14/2009 **Unknown**M 1 ☐ Yes 2 🗶 No Investigation Could not be Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number of Rural Route Number City or Town, State) 725 Cottonwood Dr. Severna Park, MD 4 Homicide determined Home within 24 hours a Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier (Check Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 3 🗆 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29b. Signature and title of certifier 1725m30n 21,2010 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) ASHINGTON MUDICAL CENAN LIMONE State

DHMH 17 Rev 7/2009

Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. Date of Death
 Month 1. Decedent's Name (First, Middle, Last) 3. Time of Death 940 AM Day Year **Physician** Worthing Adele 2 2009 /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner Hillhaven Assisted Lvg Nursing and Rehab Ctr. Adelphi Prince George's 7. Age (In yrs. last birthday) 98 yrs. If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) March24, 1911 9. Birthplace (State or Foreign 5. Social Security ... 579-03-1586 Social Security Number 6. Sex **Funeral** Days Hours Min. 1 □ M 2 💢 F Washington, DC Director Usual Residence of Decedent filed within 72 hours after death with the Maryland 10c. City, Town or Location 10d. Inside City Limits r 28a-f show notified at 1 X Yes 2 No Prince George's College Park Director Maryland 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code a or 20740 8804 Patricia Court United States "natural", or items 23a Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 秦 No If Yes, Give Year or Dates: 14. Race - American Indian Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11 Marital Status Black, White, etc. 1 ☐ Never Married 2 ☐ Married Maryland 21215-0036 White 1 ☐ Yes 🎇 No Specify: Specify 2 Widowed 4 □ Divorced Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry th and Mental Hygiene.

7 is marked other than "natu traumatic event, the Medical 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Naval Gun Factory Secretary 18. Mother's Name (First, Middle, Maiden Surname) permit. Pages 1 and 2 should be file Department of Health and Mental Hy Important: If item 27 is marked ofth any lipury or other traumatic event, once. 17. Father's Name (First, Middle, Last) Be Mary Schweinhaut Logan L. Woolard 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) -son 8812 Patricia Court College Park, Maryland 20740 William E. Worthington, Jr. Baltimore, 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20a. Method of Disposition 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State Cedar Hill Cemetery 12/18/2009 4 ☐ Donation 5 ☐ Other (Specify) Suitland, Maryland 21. Signature of Funeral Service Licenses Donald V. Borgwardt Funeral Home, PA Honold U.B 02 4400 Powder Mill Road Beltsville, Maryland 20705 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final **Physician** Failure to Thrive disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Dementia End Sta e Sequentially list conditions, if any local sequentially cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner law requires that the death certificate be executed physician and s the burial-trans Due to (or as a consequence of): Division or Vital Records, P.O. Box 68760 Physician/Medical attending p as IF FEMALE 23c. If yes, outcome pf pregnancy 1□Live birth 2□Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Month in the past 12 menths? 1 ☐ Yes 2 ☑ No Day 4☐Pregnant at time of death 5 Other (specify) 9□Unknown 9 Unknown ģ signed t 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 2 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☑Unknown Completed peen 24b. Were autopsy findings available prior to completion of cause of death?
1 □ Yes 2 ☑ No 24a. Was an s certificate has b lirector, page 2 sl autopsy the Hospital or Attending Physician; The perform ormed2 2 No 25. Was case referred to medical examiner? 26. Place of Death (Check only one) director Be Other: 4 Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 1 Yes 2 No Hospital: P 1 Inpatient 2 ER/Outpatient 3 DOA this After thi funeral of 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: 1 Natural 5 Pending investigation n 24 hours after death.
he Funeral Director #
pletely filled in by the fi 1 ☐ Yes 2 ☐ No death. 2 Accident 6 ☐ Could not be 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 3 ☐ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical To the Function 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. within 2 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifier ပ္ December 14, 2009 D51897 30. Name and address of person who completed cause of ath (Item 23a) (Type, Print) Njideka Udochi, M.D. 9055 Chevrolet Drive, #100 Ellicott City, Maryland 21042 31. Date filed (Month, Day, Year) 32 Registrar's Signature State Darke Registrar

			1 - For State Registrar		Maryland	-	artment of rtificate o		and M	ental Hy	Reg. No	000	9	42740
ľ	Physici /Medic		1. Decedent's Name (First, Middle, L Adrian	T. Westn	ey					Month Dec. 1	Da	y 009	ar	7:25p ^M
	Examir		4a. Facility Name (If not institution, g 6664 Dasher C		per)		4b. City, Town	or Location of			4c.	County of D	_	
	Funeral	16	Social Security Number 6.		. Age (In yrs. la	ast birthday) 82 _{rs.}	If Under 1 Yea	arIf Under	24 Hrs. Min.	8. Date of Bir (Month, Da	ay, Year)	9.1		ce (State or Foreign
2	Director		579-56-1448 Usual Residence of Decedent			OZIIS.				Aug. 21	l , 19	27 J	ama	aica
	larylan show ed at	j	10a. State 10b. County M D Montgo	mery	10c. City	, Town or Lo Ta	cation koma Pa	ırk					100	d. Inside City Limits 1XX es 2 ☐ No
	h the N or 28a-f o notifie	irect	10e. Street and Number				10f. Zip Code				10g. Cit	izen of What	Countr	y?
	sath wii s 23a c nust b	Funeral Director		12. Was Decede	ont Ever in 119	2 112 1		20912	ining (Cno	oifu Van ar Na		ited S		
Baltimore, Maryland 21215-0036 bernit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If them 27 is marked other than "fratural" or items 23a or 28a-f show with interest and the Medical Experiment to Applicate and the Application Experiment to Applicate and Applicate and Applicate an	ours after de ral", or item Examiner r		11. Marital Status 1 □ Never Married 3 □ Widowed 4 □ Divorced	Armed Force 1 Yes 2 If Yes, Give Year or Date	es? X No		Was Decedent of Hispanic Origin? (Spilf Yes, specify Cuban, Mexican, Puerto 1 ☐ Yes 2 No Specify:			o Rican, etc.) Black		Black, W	American Indian, White, etc. African merican	
	I within 72 he liene. r than "natu the Medical	Completed by	15. Decedent's (Specify only highest g	Education rade completed) College (1-4 5+	lor 5+)	16a. Deced (Give life. I	dent's Usual Occ kind of work dor DO NOT use reti Clerg	e during mos red)	t of warkii	ng	16b. Kind of Business/Industry Religion		stry	
	ould be filed Mental Hyg arked other atlc event,	To Be Co	17. Father's Name (<i>First, Middle, La.</i> George West	,				1	er's Name osett	(First, Middle Ca Vau	, Maiden I ghn	Surname)		
Mar	nd 2 sho Ith and 27 is ma		19a. Informant's Name/Relationship Lizette I. Westney			19b. Mailir 1206	ng Address (Stre			al Route Numb Takom a				*
ore,	permit. Pages 1 and 2 Department of Health a Important: If item 27 is any injury or other trau	1	20a. Method of Disposition 1 **Burial 2 **Cremation 3	☐Removal from St.	ata C6	emetery, crer	sition (Name of matory or other p			ate		cation - City		
Ħ.	nit. Pag artment ortant: injury o		4 Donation 5 Other (Spec	rify)	Ge	_	ashingto 2. Name and Add	- :						
<u>~</u>	Depa Impo any in	Ji J	1/1/1/1-	19-	i	7.	400 Geo:	rgia Av	venue	, NW,	Wash			-
0	hysician /Medical Examiner	86 X	23a. Part1. Enter the disease, or co shock, or heart failure. List on Immediate Cause (Final disease or condition resulting in death)	y one cause on eac a	used the death th line. ulmona as a consequ	ry Eff		ying, such as	cardiac o	or respiratory a	ırrest,			Approximate nterval Between Onset and Death
M	- 4	Examiner	Sequentially list conditions, cause. Enter Underlying Cause (Disease or injury	Due to (or	as a conse ju	ence of	ng Cance carcinom							
8760,	cate be executed physician and the burial-transit	ical	that initiated events resulting in death) Last		Due to (or as a consequence of): Coronary Atherosclerosis (ASHD)									
P.O. Box 6	ath c. rtifi ttend ng or us. as	Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown		h 2 ☐ Fetal nt at time of de	death 3]Ectopic pregnai]Other <i>(specify)</i>					23d. Date of Month		y Day Year
rds, P	equires that en signed b	by	Part II. Other significant conditions Syncope TIM	-	th but not resu	Iting in the u	nderlying cause (given in Part I		111				cause of death?
al Records,	n: The law re icate has be r, page 2 sho	Completed								24a. Was auto perfi 1□ Yes	psy ormed?	prior deat	to com h?	sy findings available pletion of cause of
Division or Vital	To the Hospital or Attending Physician: The law requires that the de within 24 hours after death. To the Funeral Director: After this certificate has been signed by the completely filled in by the funeral director, page 2 should be detached	ation: To Be	25. Was case referred to medical examiner? 1							Death (Check only one) g Home 5 Residence 6 Determine Son's 28d. Describe how injury occurred		son's residence		
Divis	ital or Atterns after derral Directo	Certification:	3 ☐ Suicide 6 ☐ Could not 4 ☐ Homicide determine	building			eet, factory, offic			City or To	Location (Street and Number or Rural Route Number, City or Town, State)			
	To the Hospital or A within 24 hours after To the Funeral Dire completely filled in b	Medical	29a. Certifier 1 A Certifying F (Check only one) 2 Medical Ex-	Physician: To the bander: On the bas aminer: On the bas and manne	is of examinat	vledge, deatl ion and/or in	h occurred at the vestigation, in m	time, date ar y opinion, dea	nd place, a ath occurr	and due to the ed at the time	cause(s , date an) and manne d place, and	r as sta due to	ited. the cause(s)
	within 2 To the complex	Me	29b. Signature and title of certifier	124	Ely1	11		nse number 3322				te signed (M		
			30 Name and address of person wh	M.D.; 75	05 New	/ Ham		venue,	Tako	oma Pa	rk,	MD 20	912	
	Sta Registr	- 9	31. Date filed (Month, Day, Year) NFC 17 200		gistrar's Signat		20							

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. for State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ 2115 Emily Jones Townsend Wilkerson Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death . Examiner ICIMICO PENINSUUM REGIONAL Salisbury If Under 1 Year If Under 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** 1 □ M 2**X** F Davs Months Hours (Month, Day, 1918) Year) Mary Land **Director** 215-38-1578 Usual Residence of Decedent "natural", or items 23a or 28a-f show edical Examiner must be notified at 10b. County 10a. State 10c. City, Town or Location 10d. Inside City Limits filed within 72 hours after death with the Maryland Director 1 Yes 2 X No MD <u>Worcester</u> Pocomoke City 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 2552 Payne Road 21851 USA 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Armed Forces Black, White, etc. 1 Never Married 2 Married ş 1 Yes 2X No Baltimore, Maryland 21215-0036 white 1 Yes 2 XNo Specify: 3X Widowed 4 □ Divorced Completed Year or Dates of Health and Mental Hygiene. item 27 is marked other than "natur other traumatic event, the Medical 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business Industry (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) sales clerk retai] 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) should be filed and Mental H ည Lloyd Townsend Annie Jones . Page 1 and 2 shou treent of Health and tant; If item 27 is m 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Donna Hardin (daughter) 2552 Payne Road, Pocomoke City, MD 21851 20a. Method of Disposition 20b. Place of Disposition (Name of Pitts Creek
Presbyterian Cametery Date 1 X Burial 2 Cremation 3 Removal from State Important; It any injury or 4 ☐ Donation 5 ☐ Other (Specify) 12/20/2009 Pocomoke City, MD 21. Signature of Funeral Service Licensee Holloway Funeral Home, Professional Association 107 Vine St., Pocomoke City, MD 21851 Micha 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician, Mya cardial disease or condition resulting in death) Medical Due to or as a consequence of) Examiner Sequentially list conditions, Examine cause. Enter Underlying Cause (Disease or linjury Due to for as a consequence of The law requires that the death certificate be executed and the burial-tran that initiated events Due to (or as a consequence of) resulting in death) Last the attending physician Physician/Medical Division of Vital Records, P.O. Box 68760 for use as IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ____ in the past 12 months?
1 Yes 2 No Pregnant at time of death 1 ☐ Yes ∠ ⊭ 9 ☐ Unknown 9 Unknown detached þ Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. signed to 23e. Did tobacco use contribute to the cause of death? Completed by 1 Yes 2 No 3 Probably 4 Unknown een Diseau Chromi ky Ir Were autopsy findings available prior to completion of cause of 24a. Was an within 24 hours after death.

To the Funeral Director: After this certificate has he completed filled in by the funeral director, page 2 s autopsy performe سدامر 1 ☐ Yes 2 ☐ No 25. Was case referred to medical examiner?

1 Yes 2 No Physician: Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) မ 1 Inpatient 2 ER/Outpatient 3 DOA 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred Certificate: Hospital or Attending 1 Natural 5 Pending 1 ☐ Yes 2 ☐ No 2 Accident Investigation Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide Medical

31. Date filed (Month DEC State Registrar

29a. Certifier

(Check

29b. Signature and title of certifier

USEPIL

mounter

MURIN 101 32. Pagistrar's Signature

CHPOREW, M

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

2009

☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
☐ Certifying Nurse Practioner: To the basis of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner stated.

204401.9

29c. License number

Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Zien

29d. Date signed (Month, Day, Year)

12-12-09

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. AMEND TTEM# 26perME, G899, 1/14/2010, WS State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No 2 1. Decedent's Name (First, Middle, Last) 2. Date of Death 15^{Day}2009^{Year} **Physician** Dec. 4:45AM Anthony Wilder /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death **Examiner** 8485 Burton Lane e Georges 9. Birthplace (State or Foreign Country) Marlboro Upper Prince 5. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) **Funeral** Hours Days Min 1 ☑ M 2 □ F Months Director 578-84-5286 Aug. 11, 1957 DC Usual Residence of Decedent 1 and 2 should be filed within 72 hours after death with the Maryland Health and Mental Hygiene.

em 27 Is marked other than "natural", or Items 23a or 28a-f show 10a State 10b. County 10c. City, Town or Location 10d. Inside City Limits Items 23a or 28a-f show Yes 2□No **Funeral Director** DC Washington 10e. Street and Number 10g. Citizen of What Country? 10f. Zip Code 1711 Irving Street NW 20010 USA 12. Was Decedent Ever in U.S. Armed Forces?

1 Yes 2 No Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 1 ☐ Yes 2 ☐ If Yes, Give Year or Dates: Never Married 2 Married 3altimore, Maryland 21215-0036 traumatic event, the Medical Examin 1 ∐Yes 2 🙀 No Specify Be Completed by Specify: Black 3 Widowed 4 Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Sanitation Worker Private Industry 11th 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Rufus Wilder, Sr. ဥ Alsie M. Jones 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) of Health a Patricia A. Wilder/Sister 2503 Heatherwood Ct. Adelphi, MD 20783 or other 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) permit. Pages 1
Department of Hi
Important: If iter
any injury or oth 20c. Location - City or Town, State 1 K Burial 2 ☐ Cremation 3 ☐ Removal from State 4 Donation 5 Dother (Specify) Lincoln 12/23/09 Brentwood,MD 22. Name and Address of Facility Latney's Funeral Home, Inc. 21. Signature of Funeral Service Licensee cc0278 3831 Georgia AVe. NW Washington, DC 20011 23a. Part 1. Enter the tuesse, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** disease or condition resulting in death) Arteriosclerotic Hypertensive Heart Disease /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any and gradient cause. Enter Underlying Cause (Disease or injury that initiated events Examiner Due to (or as a consequence of) Due to (or as a consequence of) Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy

1 Live birth 2 Fetal death
4 Pregnant at time of death 23b. Was decedent pregnant in the past 12 months?
1 □ Yes 2 □ No 23d. Date of delivery 3 Ectopic pregnancy Month Day Year 5 ☐ Other (specify) 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ò Atrial Fibrillation 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 X Unknown Completed Past CVA 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy perform 2 No 1 ☐ Yes 2 ☐ No 1 ☐ Yes

the Hospital or Attending Physician: The law requires that the death certificate be executed Box 68760. P.O. Division of Vital Records,

eral Director: After this certific filled in by the funeral director, To the Hospital within 24 hours a To the Funeral C

Be

Certification: To

Medical

State Registrar

25. Was case referred to medical examiner?

1 Xes 2 No 27. Manner of Death Natural 2 Accident 5 Pending investigation

3 Suicide 4 Homicide

(Check only one)

29a, Certifier

6 Could not be determined

Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Date of Injury (Month, Day, Year)

28b. Time of

28c. Injury at Work? 1 ☐ Yes 2 ☐ No 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Other: 4 Nursing Home 5 Residence 28d. Describe how injury occurred

26. Place of Death (Check only one)

Shaw's Refuse 6 Other (Speci

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29b. Signature and title of certifier

29c. License number 000988

29d. Date signed (Month, Day, Year) December 17,2009

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

3001 -er

31. Date filed (Month, Day, Year,

Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death Reg. No. 7 1. Decedent's Name (First, Middle, Last) 2. Date of Death Year JOHN SCOTT YOUNG December 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Death Plata Civista Medica Center Charles a 5. Social Security Number If Under 1 Year | If Under 24 Hrs. 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) 1**∕2** M 2 □ F Months Days Hours JAN.9,1945 WASH., D.C. 577-58-6007 64 Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits 1 ☐ Yes 2 No MD CHARLES LA PLATA 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 11566 DEER LANE 20646 U. S. A. 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 11. Marital Status 1 Mayes 2 ☐ If Yes, Give Year or Dates: 1 Never Married 25 Married 2 🗆 No 1 ∐Yes 2√∑No Specify: Specify: WHITE 3 ☐ Widowed 4 ☐ Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) ELECTRONICS TECHNICIAN В. F 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) JOHN MELVIN YOUNG MADGE OPAL BRADY 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) JUDITH L. YOUNG / WIFE 11566 DEER LANE LA PLATA, MARYLAND 20646 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) DECEMBER 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 27,2009 4 ☐ Donation 5 ☐ Other (Specify) METRO.CREMATORY ALEXANDRIA, VA 22. Name and Address of Facility RAYMOND FUNL.SERVICE, P.A. 21. Signature of Funeral Service Licensee 18antes Cours! M00641 5635 WASHINGTON AVE., LA PLATA, MD 20646 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Opset and Death Immediate Cause (Final epsus disease or condition resulting in death) (or as a consequence of): 5 days neemona Sequentially list conditions, if any, leading to immediate cause. Enter underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Smhe Due to (or as a consequence of) IF FEMALE: 23c. If yes, outcome of pregnancy 23b. Was decedent pregnant 23d. Date of delivery 1 Live birth 2 Fetal death 4 Pregnant at time of death 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 No Year Day 5 Other (specify) 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Parkn sons desiace 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy 1 ☐ Yes 2 No 2 No 26. Place of Death (Check only one)

Physician /Medical Examiner

Examine

Physician/Medical

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Completed

Be

Certification: To

Medical

permit. Pages 1 and 2 should be filed wit Department of Health and Mental Hygien Important: If Item 27 is marked other the any injury or other traumatic event, the Once.

Physician

/Medical

Director

Funeral

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Examiner

Funeral

Director

7 is marked other than "natural", or items 23a or 28a-f show traumatic event, the Medical Exertines must be notified at

21215-0036

Baltimore, Maryland

or Attending Physician: The law requires that the death certificate be exect has

Division of Vital Records, P.O. Box 68760

burial-trar the attending p detached director, page 2 should certificate filled in by the funeral after death Director:

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Hypercholester Oen 25. Was case referred to medical examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Tes 2 No 1 Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 28a. Date of Injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural 2 ☐ Accident 5 Pending investigation 1 ☐ Yes 2 ☐ No 3 Suicide 6 Could not be determined Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier

4 Homicide

Jan 0 7 2010

1 - certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Sign

29c. License number D46419

ess of person who completed cause of death (Item 23a) (Type, Print)

701 CHARLES ST LA PLATA, MD 2064 6 CHARLENE A LETCHFORD, MP 32. Registra's Sign

State Registrar

1441

within 24 hours a

To the Funeral D Hospital

completely

Reg. No. 2009 For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Day **Physician** December 14,2009 4:19 Umar Hassan Yusuf /Medical 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) 4c. County of Death Examiner Health Care System Horry Yours Losland A If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) Social Security Number 7. Age (In yrs. last birthday) **Funeral** Months Days Hours Min. 1 X M 2 □ F 130-40-5426 59 Director Aug. 22, 1950 New York Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits ir than "natural", or items 23a or 28a-f show the Medical Examiner must be notified at Director DC Washington 1 X Yes 2 □ No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 2913 M St. S.E. U.S.A. 20019 Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ▼Yes 2 No Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specity Cuban, Mexican, Puerto Rican, etc.) 14 Race - American Indian 11. Marital Status Black, White, etc. 1 ☑ Yes 2 ☐ If Yes, Give Year or Dates: 1 ☐ Never Married 2 ☑ Married Baltimore, MarVland 21215-0036 1 ☐ Yes 2 X No Specify. black Completed by 3 Widowed 4 Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) College Teacher 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) unknown Be Pages 1 and 2 should be I nent of Health and Mental Inez Brandon James Wilson -Ronald--Brandon-Sr. other traumatic 2 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) S 27 Munira Yusuf/daughter 2913 M St. S.E. Washington, DC 20019 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Date permit. Pages Department of Important: If it any injury or o 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 12/18/09 Laurel, Md. MarylandNational 21. Sign ture of Funeral Service Acensee 22. Name and Address of Facility Universal Mortuary 411 Kennedy St., NW Washington, DC 20011 Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** Unknawn disease or condition resulting in death) /Medical Due to (or as a con y quence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examine Due to (or as a consequence of) Hospital or Attending Physician: The law requires that the death certificate be executed and Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, attending physician Physician/Medical the IF FEMALE: 23c. If yes, outcome of pregnancy 23b. Was decedent pregnant 23d. Date of delivery Live birth 2 Fetal death 3 Ectopic pregnancy in the past 12 months? Month Day 5 Other (specify) the 1 ☐Yes 2 ☐ No. 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? à 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has autopsy perform certificate 1 □ Yes ¹□Yes 2 🗌 No 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA Certification: To 28a. Date of Injury (Month, Day, Year) funeral 27. Manner of Death 1 Natural 2 Accident 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 5 Pending 1 □Yes 2 □ No investigation after death 6 ☐ Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) à determined 4 Homicide within 24 hours a To the Funeral D 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical (Check only 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 30. Name and address of person who completed cause of death (Item 23a) (Type

Registrar

State

LIMBY Hassar

Nanz Health Care System, Perry Voint, MD. 21902

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

			r ieu.		aryland / D	epartment of h	lealth and	Mental Hy	giene		0715
		•	For State Registrar		(Certificate of L	Death		Reg. No. 200		2145
	Physicia /Medic		Decedent's Name (First, Middle, L No	Fran	cis	ASIO 4b. City, Town, o	r Location of Dea	2. Date of Dea Month	Day Y	ear 509 10	ne of Death
	Examin	er	The Johns Hopkins			Baltimore					
100	Funeral Director				e (In yrs. last birth	day) If Under 1 Year		(Month Da	th y, Year) 7 , 2000 M	. Birthplace (Sta Country) aryland	_
	and and		Usual Residence of Decedent 10a. State 10b. County		10c. City, Town	or Location				10d. Insi	de City Limits
	a-f show fied at	ctor	Maryland Carrol	.1	Ham	pstead					Yes XXNo
	or 28	Director	10e. Street and Number			10f. Zip-Code	0.5.4		10g. Citizen of Wha United St		
	eath w	eral	1238 Allview Dri	12. Was Decedent I	Ever in U.S.	13. Was Decedent of H	074 Hispanic Origin?	Specify Yes or No-	of Americ	American India	ın,
920	s 1 and 2 should be filed within 72 hours after death with the Maryland f Health and Mental Hygiene. item 27 is marked other than "natural", or items 23a or 28a-f show other traumatic event, the Medical Examiner must be notified at	by Funeral	Wantal Status Never Married 2 ☐ Married Widowed 4 ☐ Divorced	Armed Forces?		If Yes, specify Cub. 1 ☐ Yes ※XXNo	an, Mexican, Pue	rto Rican, etc.)	Specify:	White, etc. White	
21215-0036	ithin 72 ho ne. nan "natu r: Medical E	Completed	15. Decedent's (Specify only highest of Elementary/Secondary (0-12)			Decedent's Usual Occup (Give kind of work done life. DO NOT use retired	during most of w d)	rorking	16b. Kind of Busin		
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lary	2 shou and M is mar aumati		19a. Informant's Name/Relationship	(Type. Print)		Mailing Address (Street					
d'	1 and 2: Health ar tem 27 is	- 4	Katherine A. Asi	d (Mother)		Marianne D			ennsylvan 20c. Location - Ci		
nor	ages ent of h		XXBurial 2 ☐ Cremation 3 4 ☐ Donation 5 ☐ Other (Spe		cemeter	, crematory or other pla theran Ceme		an. 5, 2010	Mancheste	er, Mar	yland
Baltimore,	permit. Pages 1 and Department of Health Important: If item 27 any injury or other tr once.		21. Signature of Funeral Service Lic		12.00.	22 Name and Addr Eckhardt F 3296 Charm	ess of Facility	Chapel, P	.A.		
	* 5	. P. 19	23 Part / Enter the disease, or co	mpli alons that caused y one cause on each lir	the death. Do n					Appro	iximate al Between and Death
AL.	Physician		Immediate Cause (Final disease or condition resulting in death)	_a Tra	umatic	brain	injur	A PANIEL ON A PANCO	1/	Onser	
4	/Medical Examiner			Due to (or as	a consequence o	п):		. 11	LEXAMINEA		
	4 10	ner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	bue to (or as	3 CONSEQUENCE C	rj:	D.	A WEDER THE	,		
	be executed cian and burial-transit	Examiner	Cause (Disease or injury that initiated events resulting in death) Last	C	a consequence of	nf) ·	CERTIFICATION				
,09	e be execu sician and e burial-tra	ical E	resulting in death) Last	Dac 10 (01 do	a don boquono c	·//·	(
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of Vital		Be (25. Was case referred to medical examiner?	Hospital:		Ot	L	eath (Check only		(Specify)	
of	Physic this caral dir	2	1 Yes 2 □ No 27. Manner of Death	28a. Date of Inju	ury 28b.	Firme of 28c. Inju	ury at		idence 6 \(\sime\) Other how injury occurred		
Division	Attending Physician; or death. sector: After this certifice by the funeral director,	Certification:	1 ☐ Natural 5 ☐ Pending investiga		2009 9:		rk? ∐Yes 2∭(No	tree	fellon	subje	ect
ivis	r Atter ter dea rector	rtific	3 ☐ Suicide 6 ☐ Could no 4 ☐ Homicide determin	ed building, et	tc. (Specify)	m, street, factory, office		City or To	(Street and Number wn, State)	0 1	
	fo the Hospital or Attending Physician; within 24 hours after death. To the Funeral Director: After this certifics completely filled in by the funeral director,		29a. Certifier 1 Certifying	Physician: To the best xaminer: On the basis of	of my knowledge	death occurred at the	time, date and pl	ace, and due to the	e cause(s) and man	ner as stated.	tminster Mi cause(s)
	he Ho iin 24 h he Fui	Medical	one)	and manner s	tated.		_	occurred at the time	29d. Date signed		
	To the within 2 To the comple	Σ	29b. Signature and title of certifier			1 _	se number	0	JANUARY	_	2010
			30. Name and address of person w	ho completed cause of	death (Item 23a)				JAJOURIET		
_	2			EMAN,			60	0 North W	olfe St, Ball	imore, M	/ID, 21287
	Sta	ite.	31. Date filed (Month Day Year)	2. Registr	rar's Signa ure	ball					

DHMH 17 Rev 1/2001

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have

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

		for State Registrar	State of Ma	aryland / Dep <i>Ce</i>	artment of F ertificate of	Health and <i>Death</i>		giene Reg. No. 200	19 4274				
Physic	ian	1. Decedent's Name (First, Middle		G.			2. Date of Dea Month		3. Time of Death				
/Med Exami	ical	Fulton J 4a. Facility Name (If not institution)	Ayres,	Sr.	4h City Town o	or Location of Dea	Decembe	er 18, 200					
Exami	ner	John Hopkins I		.cal Center			ui	4c. County of Di	ediii				
Funera Director		230-12-8368	6. Sex 1 ☐ M 2 ☐ F 7. Ag	e (In yrs. last birthday 87 Yrs.	Months Days	If Under 24 Hrs Hours Min		9. E 1922 V	Birthplace (State or Foreig Country) irginia				
land ow		Usual Residence of Decedent 10a. State 10b. County	м.	10c. City, Town or L	ocation				10d. Inside City Limits				
Mary a-f sh	io	MD		Baltimo	re				1 √Yes 2 □ No				
ith the or 28	Director	10e. Street and Number			10f. Zip Code			10g. Citizen of What	Country?				
s 23a	eral	4006 Woodlea				206		USA					
iges 1 and 2 should be filed within 72 hours after death with the Maryland to 4 Health and Mental Hygiene. If item 27 is marked other than "natural", or items 23a or 28a-f show or other traumatic event, the Marical Examination must be rectified at	by Funeral	11. Marital Status 1 □ Never Married 2 🖾 Marrie 3 □ Widowed 4 □ Divorced	12. Was Decedent Armed Forces? 12 Yes 2 1 If Yes, Give Year or Dates:	10/0	Was Decedent of HIf Yes, specify Cuba 1 ☐ Yes 2 ☑ No		Specify Yes or No- to Rican, etc.)		nerican Indian, nite, etc. Black				
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ould b	2	David Ayres				Gracie							
d 2 sh th and 7 is rr traum		19a. Informant's Name/Relationsh	,					r, City or Town, State					
s 1 an f Heal ftem 2	Ш	Nannie Mable A		20h Place of Dien	6 Woodlea			, MD 2120 20c. Location - City					
Pages 1 and 2 nent of Health and 1 litem 27 is not or other tra		1 Burial 2 □ Cremation 3 4 □ Donation 5 □ Other (Sp	Removal from State	Chier Co	matory or other place rner Stor urch Ceme	ie eterv 12	2-26-09	-					
permit. Pages 1 ar Department of Hea Important: If item; any injury or other		Bapt. Church Cemetery 12-26-09 Dillwyn, Virgini 1. Signatur, If Funeral Service Licensee 22. Name and Address of Facility Reid's Funeral Home P.O. Box 247 Dillwyn, VA 23926											
Physician Medical Examiner	Examiner	28a. Part1. Enter the disease, or of shock or heart failure. List of immediate cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause (Disease or injury that initiated events	a. Pulmon Due to (or as	the death. Do not ene. ary Embolu a consequence of): a consequence of):		ng, such as cardia	c or respiratory arr	est,	Approximate Interval Between Onset and Death				
requires that the death certificate be executed seen signed by the attending physician and nould be detached for use as the burial-transit	Physician/Medical Ex	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	d23c. If yes, outcome	2 ☐ Fetal death 3 [☐ Ectopic pregnance	у		23d. Date of c Month	elivery Day Year				
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		> Illel	N M		D39221			Dec. 19,	2009				
•		30. Name and address of person wi	no completed cause of de	ath (Item 23a) (Type,		•		DEC. 17,	LINIT				
		Giorgio Galetto 31. Date filed (Month, Day, Year)	MD 4940 F	Eastern Av	enue, ASW	Room 57	3, Baltir	more, MD					
Sta Registr	.~	JAN 0 8 201	32. Hegistra	r's Signature									

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	Examir		4a. Facility Name (If not institution, gi	. 1	- 0		wn, or Location of Dea	ith	4c. County of Dea				
parti.			Frince George 5. Social Security Number 6.		yrs. last birth		ear If Under 24 Hr.	s. 8. Date of Birth	Prince	rthplace (State or Foreign			
	Funeral Director			1 M 2			Days Hours Mir		; Year) C	shington, D			
	/land		10a. State 10b. County	10	c. City, Town	or Location				10d. Inside City Limits			
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	or 28	Director	10e. Street and Number			10f. Zip Co		1	0g. Citizen of What C	country?			
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_	items items	Funeral	11. Marital Status 1 ☐ Never Married 2 X Married	12. Was Decedent Ever Armed Forces? 1 ∐Yes 2★ No	in U.S.	13. Was Deceden If Yes, specify	t of Hispanic Origin? (Cuban, Mexican, Pue	Specify Yes or No- rto Rican, etc.)	14. Race - Am Black, Whi				
)U36	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Heath and Mental Hyglene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show amy injury or other traumatic event, the Medical Examire that the inciting at once.	þ	3 ☐ Widowed 4 ☐ Divorced	If Yes, Give Year or Dates:		1 ∐ Yes 2. ⊠				ack			
က်	in 72 h n "natu Nadion	Completed	15. Decedent's E (Specify only highest gi	rade completed)	1 7	Decedent's Usual C Give kind of work o life. DO NOT use i	done during most of w	orking	16b. Kind of Business/Industry				
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2	be filed tral Hygi d other event, t	Be C	17. Father's Name (First, Middle, Las	t)			18. Mother's Na	arne (First, Middle,	Maiden Surname)				
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baltimore,	permit. Pages Department of Important: If i any injury or once.	ll y	4 ☐ Donation 5 ☐ Other (Spec		Fort_	incolm	Cem. 12/	22/20091	Brentwood	d, MD			
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			222 Part 1 Exter the disease or cor		0996					n,DC 20011 Approximate			
			23a. Part 1. Enter the disease, or cor shock, or heart failure. List only Immediate Cause (Final	one cause on each line.	geath. Do n	+ /	or dying, sacri as cardi	in III-	+ >!	Interval Between			
No sur	Physician /Medical	0.0	disease or condition resulting in death)				nder Vasci	400 17ea	it Disea	<u> </u>			
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0	nding th. tare	tion	1 ☐ Natural 5 ☐ Pending 2 ☐ Accident investigation	(Month, Day, Ye	ear) In	jury M	Work? 1 ☐ Yes 2 ☐ No						
DIVISION OF	Atter	ifica	3 ☐ Suicide 6 ☐ Could not 4 ☐ Homicide determine	be See Place of Injury	At home, fari	m, street, factory, o	ffice	28f. Location (S City or Tow	Street and Number or	Rural Route Number,			
5	ital or urs afte ral Dir lled in	Certification: To											
	To the Hospital or Attending Physician: The law within 24 hours after death. To the Funeral Director: After this certificate has completely filled in by the funeral director, page 2 to make the completely filled in by the funeral director, page 2 to make the completely filled in by the funeral director, page 2 to make the completely filled in by the funeral director, page 2 to make the completely filled in by the funeral director, page 2 to make the completely filled in by the funeral director.	Medical	29a. Certifier 1 ☐ Certifying F (Check only one) 2 ☐ Medical Example (Check only one)	Physician: To the best of maminer: On the basis of examiner stated	amination and	death occurred at l/or investigation, in	tne time, date and pla n my opinion, death od	ce, and due to the curred at the time,	cause(s) and manner date and place, and d	ue to the cause(s)			
	To the vithin to the comp	Me	29b. Signature and title of certifier	. 1 2			icense number		29d. Date signed (Mo.				
			falsada 1	Shorter D	6	14	005597	7	December	17,2009			
	(1)		30. Name and address of person who	/ / -	- 1	Type, Print)	1 201-	e Chair	December	andre			
	Sta	to	31. Date filed (Month, Day Year)	32. Registrar's	Signature	10/10	1-01/2	1 Jev	19/	y (Mad			
	Reaisti		JAN O	8 2010 Registar's	us i	9. Mark							

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Year **Physician** 8 2009 Lee Burton December /Medical 4b. City, Town, or Location of Death 4c. County of Death 4a. Facility Name (If not institution, give street and number) **Examiner** oseda vare If Under 24 Hrs. Birthplace (State or Foreign Country) 8. Date of Birth (Month, Day, Year) Sept 17, 1 . Age (In yrs. last birthday) **Funeral** Hours Months Days Min. 1 ▼ M 2 □ F 217-50-3829 Director 62 1947 Maryland Usual Residence of Decedent 10d. Inside City Limits 10b. County 10c. City, Town or Location ir than "natural", or items 23a or 28a-f show the Medical Examinar must be notified at 1 ☐ Yes 2√ No Director MD Baltimore Baltimore 10g, Citizen of What Country? 10e. Street and Number 10f. Zip Code 8662 Oak Road 21234 USA Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐Yes ≥ MNo IfYes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11 Marital Status Black, White, etc. 1 and 2 should be filed within 72 hours after Health and Mental Hygiene. 1 ☐ Never Married 2 ☐ Married 21215-0036 1 ☐ Yes 2🏋 No Specify: Specify: Completed by white 3 Widowed 4 Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) truck driver auto parts Department of Health and Mental Hygi Important; If item 27 is marked other any Injury or other traumatic event, It once. Baltimore, Maryland 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Lee Burton Sr Anna Nagle ပ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) Nancy Burton/sister 8662 Oak Road Baltimore, MD 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State Pages 1 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4□Donation 5□Othen (Specify) in state ce Licensee Wade State Anatomy Board 655 W. Baltimore Sreet inte Baltimore, MD 21201 23a. Part 1 Enter the disease, r complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Lisease or Injury that initiated events resulting in death) Last Examiner Due to (or as a consequence of): or Attending Physician; The law requires that the death certificate be executed sician and burial-trans Due to (or as a consequence of): attending physician for use as the burial Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 🔲 Ectopic pregnancy in the past 12 months? 1 □Yes 2 □ No Month Day Year 5 ☐ Other (specify) cate has been signed by the page 2 should be detached 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. <u>۾</u> 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an certificate | 1 ☐ Yes 2 ☑ No 1 ☐ Yes 2 🗆 No funeral director, 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA Medical Certification: To After this 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 5 ☐ Pending investigation 1 Natural 1 □Yes 2 □No 2 Accident filled in by the 6 ☐ Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide

Division of Vital Records, P.O. Box 68760, within 24 hours after death.

To the Funeral Director: A Hospital

State

DHMH 17 Rev 1/2001

completely

(Month, Day, Year

29b. Signature and title of certifier

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

9000

(Check only one)

ORIGINAL

🚾 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29c. License number

D36663

lin Square Drive

29d. Date signed (Month, Day, Year)

baltimore Mb. 21237

12/18/2009

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Day Month Year **Physician** 3'13 John F. Buchanan December 2009 /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner LATA ear If Under 24 Hrs. CHARLE CIVISTA MEDICAL CENTER 9. Birthplace (State or Foreign Country) Ohio 8. Date of Birth (Month, Day, Year)
May 13, 1926 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** Days Hours Months 1 ☑ M 2 □ F 83 295-20-8131 Director Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 10a State 10h County 28a-f show Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23a or 28a-f shov any injury or other traumatic event, the Medical Examiner must be notified at 1 ☐ Yes 2√☐ No Director MD Charles LaPlata 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number 9162 Cedar Street 20646 USA Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 12. Was Decedent Ever in U.S. Armed Forces? 1 X Yes 2 ☐ I If Yes, Give Year or Dates: 2 No 1 ☐ Never Married 2 X Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify. Specify: white 2 3 Widowed 4 Divorced 44-70 Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Suchanan, dohn College (1-4or 5+) military officer U.S. Army 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Samuel Clegg Buchanan Nora Christina Diehl 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) Adeline J. Buchanan/spouse 9162 CEdar Street LaPlata, MD 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition Pages ' 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☑ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee Roya Ld S Wad 22. Name and Address of Facility State Anatomy Board Baltimore, MD 21201 655 W. Baltimroe Street 23a. Par I. Enter the scease, o complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock or leart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Physician /Medical Due to (or as a consequence of): Examiner NENMONE if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Oue to (or as a consequence of) Physician/Medical Examiner Hospital or Attending Physician: The law requires that the death certificate be executed attending physician and for use as the burial-tran Due to (or as a consequence of): Box 68760, IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death
9 ☐ Unknown 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Month in the past 12 months? 1 ☐ Yes 2 ☐ No 5 ☐ Other (specify) signed by the a P.0. 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Division of Vital Records, ğ 3 Probably 4 Unknown 1 ☐ Yes 2 T N6 Completed 24b. Were autopsy findings available prior to completion of cause of death?
1 □Yes 2 □No 24a. Was an cate has by page 2 s autopsy certificate 1 □ Yes this certific al director, 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Be Hospital: Other: 4 🗆 Nursing Home 5 🗆 Residence 6 🗀 Other (Specify) 1 Yes 2 No 1 🗓 Inpatient 2 ER/Outpatient 3 DOA Certification: To After this funeral of 27. Manner of Death 1 V Natural Date of Injury (Month, Day, Year) 28b. Time of Injury 28c. Injury at Work? 28d. Describe how injury occurred 5 ☐ Pending investigation 1 ☐ Yes 2 ☐ No within 24 hours after death.

To the Funeral Director: A completely filled in by the fu 2 Accident 6 ☐ Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical and manner stated. 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifier

State Registrar

DHMH 17 Rev 1/2001

M. TOCTO

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

32. Registrar's S

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death December Physician/ 2009 2:50 PM M Neale Charles Cobry Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Baltimore Stella Maris Hospice Timonium If Under 1 Year | If Under 24 Hrs Months | Days | Hours | Min. Social Security Number 7. Age (In vrs. last birthday) 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** (Month, Day, Year) lar 25, 1948 1 🕅 M 2 🗆 F Months Country) Maryland 220-52-4006 61 Director Usual Residence of Decedent or 28a-f shov notified at 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits with the Maryland Director 1

Yes 2 □ No MD Baltimore 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? ō "natural", or items 23a or edical Examiner must be Funeral 4017 Liberty Heights Avenue 21215 USA within 72 hours after death Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14 Race - American Indian 11. Marital Status Armed Forces Black, White, etc. Ş 1 X Never Married 2 Married Yes 2X No Maryland 21215-0036 If Yes, Give Year or Dates 1 ☐ Yes 2 X No Specify: Specify: white 3 Widowed 4 Divorced Completed the Medical 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) unk 16b. Kind of Business Industry than " Elementary/Seconday (0-12) College (1-4 or 5+) merchandiser and Mental Hygie is marked other Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ည Page 1 and 2 should be ment of Health and Ment Robert Paul Cobry Rita Elizabeth Ayd 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 4411 Vale Drive Baltimore, MD Mark Cobry/brother 21236 27 Department of Health Important: If item 27 any injury or other t Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date cemetery, crematory or other place, 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 X Donation 5 → Other (Specify) Signature of Euneral Service Rona Lo State Anatomy Board 655 W. Baltimore Street Baltimore, MD 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, or heart failure. List only one cause on each line. Onset and Death Immediate Cause (Final Physician/ disease or condition PARKINSON'S DISEASE Medical resulting in death) **Examiner** Sequentially list conditions, Examiner Due to (or as a consequence of) if any, leading to immediate -transit that the death certificate be executed Cause (Disease or iinjury that initiated events and Due to (or as a consequence of): resulting in death) Last burialphysician s the burial Physician/Medical Box 68760 as IF FEMALE: nse 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery in the past 12 months? Month Dav Year signed by the a d be detached f Unknown 9 Unknown Division of Vital Records, P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ģ To the Hospital or Attending Physician: The law requires 2 No cate has been sig page 2 should b 1 Tyes 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of 24a. Was an autopsy performed death? After this certificate Yes Yes 2 🗌 No 25. Was case referred to medical after death.

Director: After this certific
d in by the funeral director, Be 26. Place of Death (Check only one) 1 Yes 2 X No 욘 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6X Other (Specify) HOSPICE 27 Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred 5 Pending work? X Natural 2 🔲 No Accident Investigation Suicide 6 Could not be within 24 hours after de To the Funeral Directo completed filled in by the 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 - Homicide Medical 29a, Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated (Check 3 🗶 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title 29d. Date signed (Month, Day, Year)

State Registrar JACKIE

31. Date filed (Month, Day, Year)

JONES

30,

DECEMBER

NEALE COBRY

TIMONIUM, MD 21093

2300 DULANEY VALLY RD.

berson who completed cause of death (Item 23a) (Type, Print)

32. Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 22 Ye a Month Physician uggins 12:56 PM imothy December 20 /Medical 4a. Facility Name (If not institution, give 4b. City, Town, or Location of Death 4c. County of Death Examiner altimore 1 Year If Under 24 Hrs. Age (In yrs. last birthday) 5. Social Security Number If Unde 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** Min. Months Days Hours Director 212-82-6002 July 19,1958 Maryland Usual Residence of Decedent filed within 72 hours after death with the Maryland 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits d other than "natural", or items 23a or 28a-f show event, the Wodfort Exercitors to rest by rediffed at Funeral Director 1XYes 2 ☐ No Md. Baltimore 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number 4121 Chesterfield Ave. 21213 USA 12. Was Decedent Ever in U.S. Armed Forces? 1 XYes 2 ☐ No Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 XYes 2 f Yes, Give 1 XNever Married 2 ☐ Married Maryland 21215-0036 1 ☐ Yes 2 No Specify Specify: White Completed by 3 Widowed 4 Divorced Year or Dates 15. Decedent's Education (Specify only highest grade completed) Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) permit. Pages 1 and 2 should be filed within Department of Health and Mental Hygiene. Important: If item 27 is marked other than any injury or other traumatic event, the Medones. Elementary/Secondary (0-12) College (1-4or 5+) 9th unemployed unemployed 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Darrell R. Duggins ဂ္ Evelyn Kase 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 8039 E. Baltimore St. Balto. Md. 21224 Cheryl Duggins Sister Baltimore, 20a. Method of Disposition
1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 12-31-2009 4 Donation 5 Dother (Specify) Bayview Balto. Md. 22. Name and Address of Facility 21. Signature of Funeral Service Schimunek Funeral Home 9705 Belair Rd. Nottingham, Md. 21236 Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** ORONADY years disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner 4PORLIPIDEMIA Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Examiner law requires that the death certificate be executed and burial-trar that initiated events resulting in death) Last Due to (or as a consequence of): P.O. Box 68760, physician Physician/Medical the for use as attending IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 5 ☐ Other (specify) the 9 Unknown 9 Unknown icate has been signed by , plige 2 should be detach Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, Completed by 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 X Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy or Attending Physician: The certificate perform 2 🗆 No 1 □ Yes 2 💢 1 ☐ Yes director, 25. Was case referred to medical Be 26. Place of Death (Check only one) niner Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1XYes 2 □ No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA this Certification: To funeral 28a. Date of Injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28d. Describe how injury occurred 28c. Injury at Work? After 1 Natural 2 Accident Injury 5 ☐ Pending 1 ☐ Yes 2 ☐ No investigation the within 24 hours after death To the Funeral Director: 6 ☐ Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by determined 4 Homicide Hospital Medical 29a, Certifier 🖄 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signat e and title of cert D0050500 and address of pe on who completed cause of death (Item 23a) (Type, Print) BALTIMORE MARY LAND FLEDERICK B. GREENE MMON 31. Date filed (Month, Day, Year, 32. Registrar's Signature State

State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ December 31, 2009 Marjorie Drescher 5:55 P^{M} Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** 4c. County of Death 216 Congressional Lane #201 Montgomery Rockville Social Security Number If Under 1 Year | If Under 24 Hrs. 6. Sex 7. Age (In vrs. last birthday 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** 1 🗆 M 2 🗶 F Oct. 22, Year) 26 Months Hours 83 New York Director 066-24-8005 Usual Residence of Decedent 10a, State 10b. County 10c. City, Town or Location 10d. Inside City Limits with the Maryland ms 23a or 28a-f sho must be notified at Director 1 X Yes 2 ☐ No Maryland Montgomery Rockville 10e. Street and Number 10f. Zip Code 10g, Citizen of What Country? Funeral 20852 216 Congressional Lane #201 United States items death 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status ıral", or iten Examiner r 14. Race - American Indian, Black, White, etc. 1 X Never Married 2 Married þ Page 1 and 2 should be filed within 72 hours after ment of Health and Mental Hygiene.
ant: If item 27 is marked other than "natural", or ury or other traumatic event, the Medical Examir Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify: Specify: White 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) Teacher Nursery School Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) မ Theodore Bausch Drescher Rolena Utrich 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Gayley Knight/Niece 2500 Virginia Avenue, NW #1408, Washington, DC 20a. Method of Disposition
1 ☐ Burial 2 🎖 Cremation 3 ☐ Removal from State 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Date Department of Important: If any injury or once, Montgomery Crematorium Bethesda, Maryland 4 Donation 5 Other (Specify) Jan. 8. 2010 21. Signature Juneral Service Cen 22 Name and Address of Facility Robert A. Pumphrey Funeral Home, 7557 Wisconsin Avenue, Bethesda, Bethesda-Chevy Maryland 20814 Chase, Inc M01530 HOUOW 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate shock, or heart failure. List only one cause on each line Interval Between Immediate Cause (Final disease or condition Onset and Death Physician/ Myocardial Infarction Medical resulting in death) Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examine Due to (or as a consequence of) Cause (Disease or injury that initiated events resulting in death) Last signed by the attending physician and be detached for use as the burial-trar Due to (or as a consequence of): Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: yes, outcome of pregnancy
Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ____ in the past 12 months? Month Dav Pregnant at time of death 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ To the Hospital or Attending Physician: The law requires 1 within 24 hours after death.

To the Funeral Director: After this certificate has hean sinn cate has been signated bage 2 should b 2 K No 3 Probably 4 Unknown Completed 1 Tes 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? Yes 2 No 1 Yes 2 No completed filled in by the funeral director, 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Hospital: Other: 4 Nursing Home 5 K Residence 6 Other (Specify) 2 No မ 1 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of injury (Month, Day, Year) Certificate: 27. Manner of Death 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 X Natural 5 Pending injury work? 1 ☐ Yes 2 ☐ No Accident Investigation Suicide 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f, Location (Street and Number or Rural Route Number ☐ Homicide determined City or Town, State) Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check only one) 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) D25348 January 3, 2010 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 15020 Shady Grove Road, Suite 300, Rockville, MD Marcia Goldmark, M.D. 20850

DHMH 17 Rev 7/2009

State Registrar JAN 0 8 2010

2. Registrar's Signature

09-09832 Ruth Ekstrom Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

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29a. Certifier (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certifier O.C.M.E. December 19, 2009 30. Name and address of person who completed cause of death (Item 23a) Russell Alexander MD. Assistant Medical Examiner 111 Penn Street, Baltimore, MD 21201	JO L		1 Moture	(Month, Day,Year)	260. Title of			200. 200020	,	
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30. Name and address of person who completed cause of death (Item 23a) Russell Alexander MD. Assistant Medical Examiner 111 Penn Street, Baltimore, MD 21201		Σ	29b. Signature and title of certifier	-11						
Russell Alexander MD. Assistant Medical Examiner 111 Penn Street, Baltimore, MD 21201			30 Name and address of	- 6 (.)	23a)					
State 31. Date filed (Month, Day, Year) 32. Registrar's Signature						1 Penn Stree	et, Baltimore, I	MD 21201		
	S	itate	31. Date filed (Month, Day, Year)	32, Registrar's Signatu	re Lond					

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Date of Death
 Month 1. Decedent's Name (First, Middle, Last) Year Physician 12:34 PM DECEMBER KAYMOND FORD 31 2009 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner SOHNS HOPKINS BAYVIEW MEOSCAL CENTER BALTIMURE If Under 1 Year | If Under 24 Hrs. 8. Date of Birth 01/18/1944 9. Birthplace (State or Foreign Country) 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) Funeral Days **X**XM 2□ F 056-36-5296 65 Director Usual Residence of Decedent with the Maryland 10a State 10c. City, Town or Location 10d. Inside City Limits Show permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryla Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, Ite Market Examiner must be rediffied at once. 1 □Yes 2X No Director VA Loudon Leesburg 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code United States 39014 Hughesville Road 20175 Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes ② No If Yes, very ever year or Dates: 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 11 Marital Status 1 Never Married 2 Married White Baltimore, Maryland 21215-0036 1 □Yes 2 No Specify: Specify: ۵ 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Attorney Legal 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Raymond Ford Alice Hart ည 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) P.O. Box 202, Hamilton, VA 20159 Nancy Ford, Wife 20c. Location - City or Town, State 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 1 ☐ Burial 2 X Cremation 3 ☐ Removal from State Atlantic Crematory 01/07/2010 Glen Burnie, MD 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility O'Connell Funeral Home 21. Si nat L Service Licensee T. Harman 120 30 Little Plains Road, Southampton, NY 11969 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** METABOLIC ACIDOSIS 6 HOURS /Medical Due to (or as a consequence of): Examiner 1 DAY RENAL FAILURE Sequentially list conditions, if an, leadin, to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to (or as a consequence of) The law requires that the death certificate be executed and burial-trar Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, attending physician for use as the buria Physician/Medical 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Month Year in the past 12 months? Day Pregnant at time of death 5 ☐ Other (specify) ☐Yes 2☐No certificate has been signed by the rector, page 2 should be detached 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 2 No 3 Probably 4 Unknown 1 🗌 Yes Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autonsy performed 2 🗆 No 1 ☐ Yes 2 No 1 Yes To the Hospital or Attending Physician: within 24 hours after death.

To the Funeral Director: After this certifica completely filled in by the funeral director, p 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1∐Yes 2∭No 1 ☑ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To 28a. Date of Injury (Month, Day, Year) 28b. Time of Injury 27. Manner of Death 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) Medical 29a. Certifier and manner stated.

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State Registrar

MARC LAROCHELLE 31. Date filed (Month, Day, -Year)

29b. Signature and title of certifier

4940 EASTERN AVENUE BALTIMORE, MD 21224

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

29c. License number

RES-000

29d. Date signed (Month, Day, Year)

DECEMBER 31, 2009

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Dav Year 2009 BARBARA ANR 4b. City, Town, or Location of Death 4c. County of Death 4a. Facility Name (If not institution, give street and number) Bel Air If Under 1 Year | If Under 24 Hrs. Hartord upper Chesapcake Medical Birthplace (State or Foreign Country) 5. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Hours Days Months 1 □ M 2 👿 F 212-62-9614 54 July 17, 1955 Maryland Usual Residence of Decedent 10d. Inside City Limits 10a. State 10b. County 10c. City, Town or Location 1 ☐ Yes 2√☐ No Harford Edgewood 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number 2402 Philadelphia Road 21040 USA 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☒ No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 Never Married 2 Married 1 ☐ Yes 2 No Specify: Specify: white 3 Widowed 4 Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation un 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) 12 5+ customer service 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Brown Burleson Margaret Marie Rankin 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Michael Fields/spouse 2402 Philadelphia Road Edgewood, MD 21030 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 Donation 5 ☐ Other (Specify) 22. Name and Address of Facility
State Anatomy Board 655 W. Baltimore Street Baltimore, MD 21201 Approximate Interval Between Onset and Death art 1. Enter the disease, if com at ations that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or he it failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) TEVERS Due to (or as a consequence of): PAROMONIA WKS Sequentially list conditions cause. Enter Underlying Cause (Disease or injury tubular FICUTE that initiated events resulting in death) Last Due to (or as a consequence of) IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death
9 ☐ Unknown 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Month Year 5 Other (specify) 1 ☐ Yes 2 Z No 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown

Physician /Medical **Examiner**

Physician

/Medical

Examiner

MD

Funeral

Director

7 is marked other than "natural", or items 23a or 28a-f show traumatic event, the Medical Examinar must be notified at

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To the Hospital or Attending Physician:

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Department o Important: If any injury or once. <u>≒</u> ö

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Physician/Medical Examiner law requires that the death certificate be executed

for use as the burial-tran phy been signed by the selection should be detached it page 2 s After this certificate funeral director, death. after death completely filled in by the

Be Completed by

Certification: To

Medical

			24a. Was an autopsy performed?	24b. Were autopsy findings available prior to completion of cause of death? 1 □Yes 2□No
25. Was case referred to medical examiner?		26. Place of Dea	th (Check only one)	
1 ☐ Yes ✓ No	Hospital: Inpatient 2 ☐ ER/Outpatient	t 3 DOA Other: 4 Nursing H	ome 5 Residence 6	G ☐ Other (Specify)
27. Manner of Death 1 Natural 5 Pending 2 Accident investigation	i	28c. Injury at Work? M 1 □ Yes 2 □ No	28d. Describe how injury	y occurred
3 Suicide 6 Could not be determined	28e. Place of Injury - At home, farm, stre building, etc. (Specify)	eet, factory, office	28f. Location (Street and City or Town, State)	d Number or Rural Route Number,
	nysician: To the best of my knowledge, death niner: On the basis of examination and/or inv and manner stated.			

29c. License number

1)66342

29d, Date signed (Month, Day, Year)

12/29/09

State Registrar

500 31. Date filed (Month, Aay, Year) JAN 0 8 2010

29b. Signature and title of certifie

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of person who completed cause of death (Item 23a) (Type, Print) Kapilkumar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

1-State Registrar Amend Item 23a per dr., g899,01/08/10dhb.30
Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death DECEMBER 19. Physician/ 2009 1:42 PM **FRANKS** SYLVIA Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** MONTGOMERY BETHESDA SUBURBAN HOSPITAL If Under 1 Year If Under 24 Hrs.

Months Days Hours Min. 7. Age (In yrs. last birthday) 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** 1 □ M 2 🛚 F 02°11'0°2'1'928 MA Director 81 019-22-6706 Usual Residence of Decedent shov 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits with the Maryland Examiner must be notified at Director 28a-f 1 Yes 2 X No **SUFFOLK** REVERE MA 10g. Citizen of What Country? 10f. Zip Code 10e, Street and Number ò Funeral "natural", or items 23a USA 02151 515 REVERE BEACH BLVD., UNIT 507 permit. Page 1 and 2 should be filed within 72 hours after death Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items any injury or other traumatic event, the Medical Examiner m Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 11. Marital Status 14. Race - American Indian, Armed Forces?
1 Yes 2 X No 1 Never Married 2 Married Completed by Baltimore, Maryland 21215-0036 1 Yes 2 No If Yes, Give Specify. Specify: WHITE 3 Widowed 4 X Divorced Year or Dates 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) OWN HOME HOMEMAKER Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) မှ BIALSKY KRISTAL BESSIE 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 70 IDLEWILD ROAD, TEWKSBURY, MA MICHAEL FRANKS/SON 20a. Method of Disposition 20b. Place of Disposition (Name of AHAVAS CACHTM other place, 1 X Burial 2 Cremation 3 X Removal from State 12-22-2009 EVERETT, MA 4 Donation 5 Other (Specify) ANSHE 21. Signature of Funeral Service Licence 22. Name and Address of Facility SOL LEVINSON & BROTHERS, INC. M REISTERSTOWN ROAD, PIKESVILLE, MD 21208 8900 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one dayse on eacylline. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ disease or condition resulting in death) Medical Due to (or as a consequence of) Examiner Dehydration Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury that initiated as or injury Examine Due to (or as a consequence of) signed by the attending physician and d be detached for use as the burial-transit CVA (stroke) that initiated events resulting in death) Last Due to (or as a consequence of): Completed by Physician/Medical Box 68760 IF FEMALE 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery Ectopic pregnancy in the past 12 menths?
1 Yes 2 No
9 Unknown Day Pregnant at time of death Other (specify) 4 ☐ Pregnant a g ☐ Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 2 No 3 □ Probably 4 □ Unknown 1 🗌 Yes 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed Yes 2 After this certificate has the Hospital or Attending Physician: The 1 ☐ Yes 2 ☐ No 25. Was case referred to medical examiner? **Division of Vital** 26. Place of Death (Check only one) Be Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 X No မှ 1 Tes 1 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28c. Injury at work? 1 ☐ Yes 2 ☐ No Certificate: 28b. Time of 28d. Describe how injury occurred injury Natural 5 Pendina Accident Investigation 24 hours after death Funeral Director: 28f. Location (Street and Number or Rural Route Number, City or Town, State) Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide determined Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Certifying Murse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier (Check

6 State Registrar

only one) 29b. Signature and title

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

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Blumenfeld, MD, Suburban Hospital 32. Registrar's Signature

29d. Date signed (Month, Day, Year)

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Please Type or Print in Black Indelible Ink, Ensure All Copies Are Legible.

AMEND TIEM#19a, perFH, G906, 8/17/2010, WS

State of Maryland / Department of Health and Mental Hygiene? () () 9 1 - State Registrar Certificate of Death Reg. No Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day Month Year FOBOLA (21LL 2009 11:00AM 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Hyattsville Prince Georges Agape Assisted Living If Under 1 Year If Under 24 Hrs. Months Days Hours Min. Aug. 27,1913 Wash., DC 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) Birthplece (State or Foreign Country) 1 □ M 2 🔀 578-62-2383 96 Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits 1 X Yes 2 □ No Hyattsville Prince Georges 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number 20782 USA 6427 24th Place 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 M No If Yes, Give Year or Dates: 11. Marital Status Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 Never Married 2 Married 1 ☐ Yes 2 X No Specify: Specify: 3 Widowed 4 □ Divorced Black 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) DC Public Schools Teacher 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) Margaretta B. Lewis James C. Lewis 19b Mailing Address (Street and Number of Rural Route Number, City or Town, State, Zip Code) 75 Oakland Street Brighton, MA 02135 19a. Informant's Name/Relationship (*Type, Print*)
James A. Phillip./Son James A. 20b. Place of Disposition (Name of 20c. Location - City or Town, State 20a. Method of Disposition Howard "University 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 11/20/09 Washington, DC 4X Donation 5 ☐ Other (Specify) Medical School 21. Signature of Funeral Service Licenses 22. Name and Address of Facility Austin Royster Funeral Home 3821 14th Street, N.W., Washington, DC20011 23a. Part1. Enter the stease, or complications that caused the shock, or hear aifure. List only one cause on each line. Approximate interval Between Onset and Death earn. Onot enter the mode of dying, such as cardiac or respiratory arrest, Immediate Cause (Final disease or condition resulting in death) alzheimers disease years Due to (or as a consequence of) So menticly list conditions if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Due to (or as a consequence of): resulting in death) Last Due to (or as a consequence of): 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant in the past 12 months?
1 □ Yes 2 ☑ No 23d. Date of delivery 3 Ectopic pregnancy Month Day Year 4☐Pregnant at time of death 5 Other (specify) 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 3 Probably 4 Unknown 1 ☐ Yes 2 ☐ No 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? 1 ☐ Yes 2 ☐ No 1 ☐ Yes 25. Was case referred to medical examiner? 26. Pface of Death (Check only one) Hospital: 1 ☐ Yes 2 ☑ No Other: 4 Nursing Home 5 Residence 6 Other (Specify) ALF 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 DOA 28a. Date of Injury (Month, Day Year) 27. Manner of Death 1 Natural 28c. Injury at Work? 28b. Time of 28d. Describe how injury occurred Injury 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be determined 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of fnjury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide

Examiner Hospital or Attending Physician: The law requires that the death certificate be executed attending physicien and for use as the burial-transit Division of Vital Records, P.O. Box 68760, ል signed l been si this certificate : After this certifical funeral director, I Director: And in by the f

Physician

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Certification:

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29a. Certifier

(Check only one)

31. Date filed (Month,

Funeral

Director

Pages 1 and 2 should be filed within 72 hours after deeth with the Maryland nent of Health and Mental Hygiene. and to them 27 is marked other then "natural", or items 23s or 28s-1 show

Baltimore, Maryland 21215-0036

27 is marked other than "natural", or tema 23a or 28a-f show traumatic svent, the Medical Examinar must be notified at

permit. Page Department of Important: If any injury or once.

Physician

/Medical

within 24 hours e To the Funeral D

State

Registrar

29b. Signature and little of certifie

29c. License number

1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29d. Date signed (Month, Day, Year)

025001

LINTHOUM

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

DIGITAL DR 705

32. Redistrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

			For State	State of Marylan				Mental H				
			Registrar		Cei	tificate of L	Jeath 	2. Date of	Reg. No.	2009	330	2758
ne -	Physicia	an	Decedent's Name (First, Middle, Last) Pogements		ī	leath		Month Deceml	Day	Year 2009		55 P ^M
	/Medic		Rosemary 4a. Facility Name (If not institution, give s	treet and number)	1	4b. City, Town, or	Location of Deat			County of Dea		JJ 1
į.	Examin	er	19112 Peach Blosso			Gaither	sburg		Mo	ntgome	ry	
7	Funeral		5. Social Security Number 6. Sex	7. Age (In yrs. i	ast birthday)	If Under 1 Year Months Days				9. Bi		tate or Foreign
ы	Director	1	228-22-6085	M 2XF 88	Yrs.	Worldis Days	Tiodio Willia	Nov. 2				rginia
	pul w		Usual Residence of Decedent 10a, State 10b, County	10c. City	, Town or Lo	cation					10d. Insi	de City Limits
	laryla shov ed at	ō	, , , , , , , , , , , , , , , , , , , ,	2	. 1 . 1	1 1					1 🔯	¶Yes 2□No
	the N 28a-1 outifi	Director	PA Fayette 10e. Street and Number	Spr	'ingni	1 Townsh:	1p		10g. Citi	zen of What C	Country?	
	with 3a or 1 be		330 Gans Road			15439			U.S.	Α.		
	ms 2;	nera		Was Decedent Ever in U. Armed Forces?	S. 13.	Was Decedent of H	ispanic Origin? (S	Specify Yes or		14. Race - An Black, Wh		an,
Maryland 21215-0036	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hyglene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show amy injury or other traumatic event, the Medical Examiner must be notified at Once.	Completed by Funeral	1 ☐ Never Married 2 ☐ Married 3 🛣 Widowed 4 ☐ Divorced	1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates:		1 ☐ Yes 2 🗓 No	Specify:	to ritean, etc.,		Specific	hite	
0	2 hou	ted	15. Decedent's Educ (Specify only highest grade	cation	16a. Dece	dent's Usual Occup	ation	nrkina	16b. Ki	nd of Busines	s/Industry	
218	thin 7	nple	Elementary/Secondary (0-12)	College (1-4or 5+)		kind of work done o DO NOT use retired	1)	. 3		77		
21	led w lygier her th nt, the		12		Hon	nemaker	18. Mother's Na	me (First Mid		n Home		
gue	ntal H ed otl	Be	17. Father's Name (First, Middle, Last) John W. Taylor				Deborah	, .		ourname)		
7	hould id Me mark matic	မှ	19a. Informant's Name/Relationship (Type	oe. Print)	19b. Mailir	ng Address (Street				r Town, State	, Zip Code)	
Σ	nd 2 s Ith an 27 is rtrau		Lisa Pocratsky (Da			Peach B					_	0879
ē,	s 1 ar f Hea item 2		20a. Method of Disposition	20b. F		osition (Name of matory or other place		Date		ocation - City of		ate
E O	Pages ent o nt: If		1 ☐ Burial 2 【Cremation 3 ☐ R 4 ☐ ponation 5 ☐ Other (Specify)	emoval from State I		Ltan Crem		5/10	Alex	andria	, VA	
Baltimore,	permit. I Departm Importal any inju		21. Signature of Funeral Service Incent	+	I Z	2. Name and Addre	ss of Facility Rudolph	Funera:	L Home	15/7/		
			23a. Part1. Enter the disease, or complishock, or heart failure. List only or	cations that caused the deat		L5 Main S ter the mode of dyir				1 1 3 4 / 4		oximate ral Between t and Death
Į.	Physician		Immediate Cause (Final	Non Small (Onse	t and Death nonth
Z	/Medical		disease or condition resulting in death)	Due to (or as a conseq								
B	Examiner		Sequentially list conditions).								
	P. H	iner	Sequentially list conditions, if any, leading to immediate cause. Little binderlying Cause (Disease or injury that initiated events	Due to (or as a conseq	uence of):							
	recute and -trans	Examiner	that initiated events resulting in death) Last	Due to (or as a conseq	uence of):						-	
8760,	icate be executed physician and s the burial-transit											
687	ficate phys	edical										
Box (eath certific attending p for use as	Physician/Me	IF FEMALE: 23b. Was decedent pregnant 2	3c. If yes, outcome pf pregna		75-4				23d. Date of	delivery	
	death e atte d for	icia	in the past 12 months? 1 ☐ Yes 2 🛣 No	1 ☐ Live birth 2 ☐ Feta 4 ☐ Pregnant at time of c		□Ectopic pregnance □ Other (specify)	у		_	Month	Day	Year
P.0	that the de ned by the a detached t	hys	9 🗆 Unknown	9□Unknown								
Vital Records, F	8 7 9	by	Part II. Other significant conditions con	ntributing to death but not res	ulting in the u	ınderlying cause giv	ven in Part I.		Yes 2	use contribute ☐ No 3點		se of death? 4 □Unknown
000	law require as been się 2 should b	Completed						24a. V		24b. Were	autopsy fin	idings available on of cause of
Re	The la ate ha page 2	E O				···		p 1□ Ye	utopsy erformed? es 2፟፟፟፟፟፟Σ No	death	?	
ita		Φ	25. Was case referred to medical examiner?				26. Place of De	eath Check or	nl one		Daug	hter!t
or V	lis dir	To B	1 ☐ Yes 2 ☑ No	Hospital: 1 ☐ Inpatient 2 ☐		III 3 DOA		Home 5□F			pe Ry si	dence
n o	ding Ph n. After th funeral		27. Manner of Death 1 ☑Natural 5 ☐ Pending	28a. Date of Injury (Month, Day Year)	28b. Time o Injury	Wo		28d. Descri	be how inju	ry occurred		
sio	Attending r death. ector: After by the fune	cati	2 ☐ Accident investigation 3 ☐ Suicide 6 ☐ Could not be	28e. Place of injury - At h	omo farm et		Yes 2 □No	28f Locatio	n (Stroot a	nd Number or	Rural Rout	te Number
Division	I or Attend after death I Director: A	Certification:	4 ☐ Homicide determined	building, etc. (Speci	fy)	reet, ractory, office		City or	Town, Stat	e)	Tranci Trock	o rumbor,
_	To the Hospital or within 24 hours after To the Funeral Director Completely filled in b	Medical C	29a. Certifier 1 Certifying Phy (Check only one) 2 Medical Exami	sician: To the best of my kno ner: On the basis of examina and manner stated.	owledge, dea ation and/or i	th occurred at the tinvestigation, in my	ime, date and pla opinion, death oc	ce, and due to curred at the ti	the cause(s me, date ar	s) and manner ad place, and	as stated.	cause(s)
	o the ithin o the omple	Mec	20h Signature and title of certifier			29c. Licens	se number		29d. Da	ate signed (Mo	onth, Day,	Year)
h	F ≤ F ō		> Poseph m. t.	taggerty mo) _	D324	₄ 07		Dec	ember	28, 20	009
			30. Name and address of person who co	ompleted cause of death (Iter	m 23a) (Type	, Print)						
			Joseph Haggert	y, MD 9707 Me	dical	Center Dr	. Rockv	ille, M	D 208	50		
		ate	31. Date filed (Month, Day, Year) JAN 0 8 2010	32. Registrar's Sign	ature	S						
	Regist	ıdl		LEWING B.		_						

DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. Amend #5, per Inf G900 2/2/10 TT State of Maryland / Department of Health and Mental Hygiene Reg. No. 2 1 9 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death **Physician** JAMES JOHNSON JR DECEMBER 23 2001 /Medical 4b. City, Town, or Location of Death 4c. County of Death 4a. Facility Name (If not institution, give street and number) Examiner BAYUTEW JOHINS HOPKINS 5. Social Security Number 330 - 64 - 6750 Birthplace (State or Foreign Country)
_ 6. Sex **Funeral** MO Director Usual Residence of Decedent filed within 72 hours after death with the Maryland Hygiene. 10c. City, Town or Location 10d. Inside City Limits 10a. State 10b. County permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylar Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "natural", or Items 23a or 28a-f show any Injury or other traumatic event, the Medical Examiner must be notified at 1 Yes 2 No NA BALTIMORE Directo MAD 10e. Street and Number 10g. Citizen of What Country? 16 KING 21222 AVENUE U.S. A Funeral 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. 11. Marital Status Black, White, etc. f Yes 2 No If Yes, Give Year or Dates: 1 Never Married 2 Married 1 ☐ Yes 2 ☐ No Baltimore, Maryland 21215-0036 Specify: Specify: Black

16b. Kind of Business/Industry þ 3 ☐ Widowed 4 Divorced Be Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) Edgemire lernial 2 years Truck 18. Mother's Name (First, Middle, Maiden Surname 17. Father's Name (First, Middle, Last) Johnson Deloies Freeman ၉ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 4093 C. Ave. N. Z., Nagel MS 391 19a. Informant's Name/Relationship (Type. Print) AUC. N. E. Magee I142a 20a. Method of Disposition

1 Burial 2 Cremation 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 3 ☐Removal from State (remastory) 4 □ Donation 5 □ Other (Specify) 12/31/09 21. Signature of Juneral Service Licensee 22. Name and Address of Facility
March F/H West 4300 WabashAve, Baltimore, Md 21215 Fart1. Enter the disease, or complication in a caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Gastraintestinal Immediate Cause (Final Massive **Physician** day disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Alcohol Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examine attending physician and Due to (or as a consequence of): Box 68760, Completed by Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy 4☐Pregnant at time of death 9☐Unknown Month Year in the past 12 months? 5 Other (specify) 1 ☐ Yes 2 ☐ No 9 Unknown ۵. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division or Vital Records, 1 ☐ Yes 2 No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☐ No autopsy performed? Yes 2 No ial or Attending Physician: The safter death.

In Director: After this certificate of in by the funeral director, par 25. Was case referred to medical examiner?
1 ☐ Yes 2 ☐ No Be 26. Place of Death (Check only one) Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) Certification: To 28a. Date of Injury (Month, Day Year) 27. Manner of Death 1 Natural 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide 1 certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical and manner stated. 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifier 1 MEDICAL DOCTOR RES-ULO DECEMBER 33, QUUT Fred cituse of death (Item 23a) (Type, Print)

SUHNS HOPICINS BAYVIEW, 44 to EASTERN AVE BALTMORE address of person who completed chuse of death (Item 23a) (Type, Print) 0 LYNCH ONALD 31. Date filed (Month, Day, Year) 3. Registrar's Signature **JAN 0 8 2010** Registrar

DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

			1 - For State Registrar	State of Marylan		artment of Hertificate of E			iene 009	42760
	Physici /Medi	cal	1. Decedent's Name (First, Middle, Las ORMA 4a. Facility Name (If not institution, give	, JENKI	NS	4b. City. Town, or	Location of Deat	2. Date of Deal Month	Day Year 27/200	3. Time of Death 5 3 5 A M
建	Funeral	ter	Alice Many 5. Social Security Number 6. Se	or Nusy no		Balt If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth	Ygar) 9. Bir	thplace (State or Foreign ountry) unk
	Director Moye	ŗ	Usual Residence of Decedent 10a. State 10b. County	10c. City	, Town or Lo			11/29	[193]	10d. Inside City Limits 1 ☆Yes 2 ☐ No
	death with the Maryland me 23s or 28e-f ehow rmast be rediffed at	ai Director	MD 10e. Street and Number 2095 Rockrose A		Baltim	10f. Zip Code	211	1	0g. Citizen of What Co	11
036	urs after deat el', or iteme 2 Exercit er mu	by Funeral	11. Marital Status 1 Never Married 2 Married 3 Widowed 4 XDivorced	12. Was Decedent Ever in U. Armed Forces? 1 ☐ Yes 24☐ No If Yes, Give Year or Dates:		Vas Decedent of His f Yes, specify Cuban ☐ Yes 2	spanic Origin? (S n, Mexican, Puert Specify:	pecify Yes or No- o Rican, etc.)	14. Race - Ame Black, Whit	te, etc.
21215-0036	be filed within 72 hours after death with the Marylar lat Hygliene. Id other then "naturel", or iteme 23s or 28e-f ehow other then "naturel", or iteme 23s or 28e-f ehow event, I'm Medical Exacric acriment to rediffed at	Completed	15. Decedent's Ed (Specify only highest grad Elementary/Secondary (0-12) unk	ucation <i>de completed)</i> College (1-4or 5+)	(Give	ent's Usual Occupat kind of work done do OO NOT use retired)	urina most ol woi	king unk	16b. Kind of Business	/Industry unk
yland		To Be C	17. Father's Name (First, Middle, Last)		Ţ	dik		ne (First, Middle, I	7	unk
поге, маг	Pages 1 and 2 should hent of Health and Mer int: If Item 27 ie marke iry or other traumatic		19a. Informant's Name/Relationship (7. Union Memorial Ho 20a. Method of Disposition 1 Burial 2 Cremation 3 Di 1 Description 5 Mother (Secrification)	Spital Removal from State	201 I	g Address (Street ar E. Univers sition (Name of natory or other place	sity Pkw	y Baltimo	City or Town, State, one, MD 2.	1218
Бацито	permit. Pages Department of Important: If it eny injury or o		semy	Wad Wrector	St Ba	ll Elmore.	my Boar MD 212		Baltimore	Street
	/Medical Examiner	Examiner	23a. Palt1. Enter the disease, or compshobs, or heart failure. List only commended to the commendate cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events	a	obst vence of): nta	rective /	, such as cardiac	or respiratory arra	est,	Approximate Interval Between Onset and Death
O. DOX 66/60,	The law requires that the death certificate be executed attentas been signed by the attending physicien and page 2 should be deteched for use as the burial-transit	Physician/Medical Ex	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 Yes 2 No 9 Unknown	Due to (or as a consequence) d	ncy death 3	Ectopic pregnancy Other (specify)		25-465	23d. Date of de Month	livery Day Year
oras, r.	w requires that t been signed by should be deter	ρ	Part II. Other significent conditions co	ntributing to death but not resu	Iting in the un	derlying cause giver	n in Part I.		pacco use contribute to	o the cause of death?
שו שבים		Completed						24a. Was an autops: perform	y prior to	utopsy findings available completion of cause of
וסוו סו אינם	To the Hospitel or Attending Physicien: The law within 24 buturs after death, within 24 buturs after death. To the Funeral Director: After this certificate has completely filled in by the funeral director, page 2	ation: To Be	25. Was case referred to medical examiner? 1 Yes No 27. Manner of Death Notural 5 Pending 2 Accident investigation	Hospital: 1 Inpatient 28a. Date of Injury (Month, Day Year)	ENOutpatient 28b. Time of Injury	3□ DOA Other 28c. Injury : Work?	4 Nursing H	th Check only one ome 5 Reside 28d. Describe ho	ince 6 ☐ Other (Spe	ocify)
	oltel or Atteurs after de rail Directo	Certification:	3 ☐ Suicide 6 ☐ Could not be determined	28e. Place of Injury - At hos building, etc. (Specify)			City or Town		
	o the Hosp vithin 24 ho o the Fune ompletely fi	Medical	29a. Certifier (Check only one) 1 Certifying Phy 2 Medical Exami	sician: To the best of my knowner: On the basis of examinat and manner stated.	vledge, death ion and/or inv	occurred at the time estigation, in my opin 29c. License	nion, death occu	rred at the time, da	ause(s) and manner as ate and place, and due	to the cause(s)
	- S - Ö		30. Name and address of person who co	ompleted cause of death (Item	23a) (Type, f	D47	407	1	430/09	
و	Sta Registr		S2/ N EN 31. Date filed (Month, Day, Year) 1800 Q 2010	Sz. Registrar's Signat	Back	are	MD	2/20	1	

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death Reg. No. 2 1. Decedent's Name (First Middle, Last) 2. Date of Death Month [Physician/ eukin Medical Facility Name (if not institution, give street and num 4c. County of Death 4b. City, Town, or Location of Death Examiner Wany NIUDISH Medical FINNOVE Year If Under 24 Hrs Social Security Number 8. Date of Birth 9. Birthplace (State or Foreign If Under 1 7. Age (In yrs. last birthday) **Funeral** (Month, Day, oV 18. 213-62-222 1 M 2 D F Months Hours Min Mary Land Nov Director Usual Residence of Decedent 28a-f shov 10a. State 10b. County 10d. Inside City Limits 10c. City, Town or Location with the Maryland notified at Director TX□ Yes 2 □ No MD Baltimore 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? ŏ ed other than "natural", or items 23a or event, the Medical Examiner must be Funeral 3330 Wilkens Avenue 21229 USA 72 hours after death 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-11 Marital Status Race - American Indian. Armed Forces?
1 ☐ Yes 2 🖾 No Yes, specify Cuban, Mexican, Puerto Rican, etc.) Black, White, etc. \$ 1 Never Married 2 Married Maryland 21215-0036 If Yes, Give Year or Dates 1 ☐ Yes 2 X No Specify: black 3 Widowed 4 X Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) and Mental Hygiene. is marked other than Elementary/Seconday (0-12) self employed car wash Be unk unk 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ပ္ 19a, Informant's Name/Relationship (Type, Print. 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Page 1 and 2 sh
Department of Health ar
Important: If item 27 is Crystal Veniey/daughter 20 Richmar Road #c Owings Mills, MD 21117 Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State cemetery, crematory or other place) 1 Burial 2 Cremation 3 Removal from State 4 □ Donation 5 🗓 Other (Specify) in state, 21. Signature of Funeral Service 22. Name and Address of Facility State Anatomy Board Baltimore, MD 2120 ,655 W. Baltimore Street Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. 23a. Part 1 Approximate Interval Between Onset and Death Immediate Cause (Final Physician disease or condition resulting in death) Medical Due to (or as a consequence of): Examiner Sequentially list conditions. if any, leading to immediate cause. Enter Underlying Due to (or as a consequence of): To the Hospital or Attending Physician: The law requires that the death certificate be executed Jause (Disease or ilinjur burial-tran that initiated events resulting in death) Last Due to (or as a consequence of) physician a the burial-Physician/Medical P.O. Box 68760 the attending posterior IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months?

1 Yes 2 No Month Year Pregnant at time of death 5 Other (specify) 9 Unknown 9 Unknown signed by the Part, II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? by Division of Vital Records, 2 No 3 Probably 4 Unknown s been signature should b Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an is certificate has to director, page 2 s autopsy autope, performed 1 Yes 2 No Yes 2 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 No ည 1 Inpatient 2 ER/Outpatient 3 DOA After this funeral 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred Certificate: 5 Pending 1 Natural death, 1 🗌 Yes Accident Investigation within 24 hours after death

To the Funeral Director:
completed filled in by the 3 Suicide 6 Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) Place of Injury - At home, farm, street, factory, office building, etc. (Specify) Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated 29a. Certifier (Check Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

State Registrar

29b. Signature and title of certifie

31. Date filed (Month, Day, Year)

JAN 0 8 201

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Orlibuc

29d. Date signed (Month, Day, Year)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1, Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death_ Physician/ Dav Year 2009 <u>Charles Andrew K</u>ehoe Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death Square 050 rantlin daye imore Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign Funeral Days Hours 1 X M 2 □ F August 1,1916 Maryland Director 93 213-01-8751 Usual Residence of Decedent permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f shown injury or other traumatic event, the Medical Examiner must be notified at once. 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director Nottingham Balto. Md. 1 Yes 2 X No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Completed by Funeral USA 2 Rosecrans P1. Apt.2-D 21236 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian Black, White, etc. 1 X Yes 2 No If Yes, Give 1 Never Married 2 X Married Baltimore, Maryland 21215-0036 White 1 Tes 2 No Specify: 3 Divorced 4 Divorced Year or Dates.1944-1946 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) Optical Company Optician Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ပ Mary Marx Charles Kehoe 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Spouse Dorothy Kehoe Rosecrans Pl. apt.2-D Nottingham, Md. 20a. Method of Disposition 20b. Place of Disposition (Name of Date 20c. Location - City or Town, State cemetery, crematory or other place) 1-5-2010 Balto.Md. Most Holy Redeemer Schimunek Funeral Home 21. Signature of Funeral Jervice Licensee 22. Name and Address of Facility 9705 Belair Rd. Nottingham, Md. 21236 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ disease or condition resulting in death) Medical Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury that initiated events Physician/Medical Examiner Due to (or as a consequence of): To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completed filled in by the funeral director, page 2 should be detached for use as the burial-transit 0+ Due to (or as a consequence of) resulting in death) Last Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery in the past 12 months? Day Year Pregnant at time of death 2 🗌 No 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed 1 ☐ Yes 2 ☐ No Yes Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital Other: 2 🗖 No Certificate: To 1 🗌 Yes 1 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) 27. Manner of Death Date of injury 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 🛮 Natural (Month, Day, Year) 5 Pending work? 1 ☐ Yes 2 ☐ No Accident Investigation Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated only one) 29b. Signature and title of ce 29d. Date signed (Month, Day, Year) 09 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) State

DHMH 17 Rev 7/2009

Registrar

Registrar
DHMH 17 Rev 1/2001

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		4a. Facility Name (if not institution Northwest Hospital Co		umber)			Town, or Lo Ialistown	ocation of Death			County of altimore		
Funeral		5. Social Security Number	6 Sex	7. Age (In	yrs. last birthday)	_	ler 1 Year	If Under 24Hrs. Hours Min.	8. Date of	Birth (MM/I		9. Birthplace Foreign	
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altimore, MD 21215-0036 mit. Pages I and 2 should be filed within 7 partment of Health and Mental Hygiene. portant: If item 27 is marked other than ury or other traumatic event, the Medica		20a. Method of Disposition 1 Burial 2 Cremation	n 3 Removal fi		20b. Place of Disp crematory or	osition (Na	me of ceme		Date 20c. Location - City or Town,				
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Division of Vital I To the Hospital or Attending Physician: within 24 hours after death. To the Funeral Director: After this certifi completely filled in by the funeral director,	Certification: T	27. Manner of Death 1 X Natural 5 Pence P	ding stigation	n, Day,Year)	28b Time			s 2 No	28d Describ				to Number City
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E ≯ E 8	Me	29b. Signature and title of certific		Qd a		29	c. License i				Date signed uary 5, 2	(Month, Da	ay, Year)
		30 Name and address of person Carol Allan, MD As	who completed caussistant Medical			Street,	Baltimor	e, MD 2120	1				

State Registrar 31 Date filed (Month Cal Year) 8 2010 32. Registrar's Signature

A. Jakel
ORIGINAL

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene 009 1 - State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death $\frac{\text{Month}}{12}/01/2009$ Physician 5:30 AM Vernell M. Lott /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner Silver Spring, Montgomery Woodside Center If Under 1 Year | If Under 24 Hrs. Birthplace (State or Foreign Country) 5. Social Security Number 7. Age (In yrs. last birthday) Date of Birth (Month, Day) **Funeral** Year) Days Min 1 □ M 2 🖫 F 67 579-54-3225 02/14/1942 Washington, DC Director Usual Residence of Decedent 10d. Inside City Limits filed within 72 hours after death with the Maryland 10c. City, Town or Location 10a, State 27 Is marked other than "natural", or items 23a or 28a-f show traumatic event, the firstlich Exprisive must be notified at 1⊈Yes 2□No Director DC Washington, DC 10g. Citizen of What Country? 10e Street and Number 20002 722 7th Street NE USA Funeral 14. Race - American Indian, Black, White, etc. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S Armed Forces? 11 Marital Status 1 □Yes 2X No If Yes, Give Year or Dates: 1 ☐ Never Married 2 ☐ Married Specify: Black Baltimore, Maryland 21215-0036 1 ☐Yes 2X No Specify. þ 3 Widowed 4 □ Divorced Completed 16a Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) I Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) Private Industry Maintenence Worker 10 permit. Pages 1 and 2 should be filed to Department of Health and Mental Hygin Important; If item 27 Is marked other any Injury or other traumatic event, III 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Rachel Smith Fred Gray 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 2920 Nelson Place SE #3, Wash, DC 20019 Ronald L. Lott/Son 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 1 ☐ Burial 2 X Cremation 3 ☐ Removal from State 12/19/09 Beltsville, MD 4 ☐ Donation 5 ☐ Other (Specify) Chesapeake Crem. 22. Name and Address of FacilityAustin Royster Funeral Home 21. Signature of Funeral Service Licensee Moo996 3821 14th Street NW, Wash, DC, 20011 23a. Part 1. Exter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final 1425 **Physician** disease or condition resulting in death) /Medical Due (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examine law requires that the death certificate be executed attending physician and for use as the burial-transit Due to (or as a consequence of): P.O. Box 68760, Physician/Medical 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Month in the past 12 months? 1 ☐ Yes 2 ☑ No 5 Other (specify) ned by the detached 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? signed I Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Division of Vital Records, δ ANDIDEMIN 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Johknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has autopsy performed? e Hospital or Attending Physician; The 24 hours after death.

Puneral Director; After this certificate h 1 ☐ Yes 2 ☐ No 1 □Yes 2 DMo 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: Other: 4 University Home 5 Residence 6 Other (Specify) 1 Tes 2 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To 28a. Date of Injury (Month, Day, Year) completely filled in by the funeral 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 ☐ Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical (Check only one) and manner stated. To the I within 2 29d. Date signed (Month, Day, Year) 29b. Signature and Attl 29c. License number 12-01-2009 len 0057630 MAS 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 209. SILVER SPACINGIMI) 20902 31. Date filed (Month, Day, Year) 32. Regist

DHMH 17 Rev 1/2001

State

Registrar

2010

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amend items 25, 28f per me 8899, 1–8–10 yr.
State of Maryland / Department of Health and Mental Hygiene

			For State Registrar	State of Ivial	ylanu /	•	tificate of l		ена пу	Reg. No. 2	00 1.2766
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Baltimore,	permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any Injury or other traumatic event, If a Medical Expringer must be rotified at once.		21. Signatur Funeral Service Ligens	Hereols		Mc 13	Name and Address COMAS FU	ss of Facility Ineral Hor Sbury Rd	ne, P.A.	don, MD 2	21009
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			30. Name and address of person who co	mpleted cause of dea	ith (Item 23a	ay (Type, Pi	rint)	· ct	2.01-		12619
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item item	Dec	Funeral Director	11. Marital Status	12. Was Decedent Ever in Armed Forces?	0.8.	If Yes, sp	edent of tecify Cub	Hispanic Origin'i an, Mexican, Pu	' (Specify Yes or N Jerto Rican, etc.)	10-	4. Hace - Am Black, Whi	nerican Indian, ite, etc.
ours af	E	by	1 ☐ Never Married 2 💢 Married 3 ☐ Widowed 4 ☐ Divorced	1 Yes 2 No If Yes, Give Year or Dates:		1 □Yes	2 💢 No	Specify:			Specify: T.T.	hite
2 hou	S S	ted	15. Decedent's E	Education	16a. I	Decedent's Us	ual Occu	pation		16b. Kin	w. nd of Business	
in 1. 1. 1. 1. 1. 1. 1. 1. 1. 1. 1. 1. 1.	Medi	ple	(Specify only highest g. Elementary/Secondary (0-12)	College (1-4or 5+)	1 (Give kind of w life. DO NOT	ork done	during most of	working			
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al Hy	vent	Be (17. Father's Name (First, Middle, Las	it)		-		18. Mother's I	Name (First, Middl	e, Maiden S	Surname)	
uld b Ment	rtic e	2	Gerrit Van Maane	n				Janna	VanBins	berge	n	
al y	E I	11	19a. Informant's Name/Relationship	(Type. Print)	19b. I	Mailing Addres	ss (Street	and Number or	Rural Route Num	ber, City or	Town, State,	Zip Code)
and and a	er tr		William Lamers	(Husband)	134	409 Str	aw B	ale La.	, Gaithe	rsbur	g, MD	20878
es 1	듄		20a. Method of Disposition 1 X Burial 2 ☐ Cremation 3 [20h	Place of E	Disposition (Na crematory or	ame of other pla	ce)	Date	20c. Loc	ation - City o	r Town, State
Pag ment ant: I	ury		4 □ Dopation 5 □ Other (Spec	in hemoval nom State				i	12/31/09	Web	ster,	NY
permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show	any inj once.		21. Signature of Funeral Service Live						Funeral			
205	æ 8		Jenn J	Ullum					er, NY 1			
			23a. Part 1. Enter the disease, or cor shock, or heart failure. List only	nplications that caused the de y one cause on each line.	eath. Do no	ot enter the mo	ode of dyi	ng, such as card	diac or respiratory	arrest,		Approximate Interval Between
Physic	ian		Immediate Cause (Final disease or condition	_a Pneumonia								Onset and Death
/Medi Exami	_		resulting in death)	Due to (or as a cons	equence of):						
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eath certificate be executed attending physician and	s the	cian/Medical		d .								
eath certific	nse a	Ž	IF FEMALE: 23b. Was decedent pregnant	23c. If yes, outcome of preg	gnancy					2	3d. Date of de	alivery
	d to		in the past 12 months? 1 □Yes 2 ☑No	1 Live birth 2 Fe	etal death of death	3 ☐ Ectopic 5 ☐ Other (s	pregnand specify) _	У			Month	Day Year
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quires en sign	g pl	8							_ 1 🗆	Yes 2 🔀]No 3 ☐ F	orobably 4 ☐ Unknown
aw re	2 should	Completed							24a. Wa	s an	24b. Were a	autopsy findings available
The la	page	Ē							perf	opsy ormed?	death?	
	or,	Be C	25. Was case referred to medical					26 Place of D	1 ∐Yes Death (Check only	2 XNo	1 □Ye	s 2□No
lysic lis ce	direc	일	examiner? 1 ☐ Yes 2 X No	Hospital: 1 ☐ Inpatient 2	☐ ER/Outp	atient 3□D	OA Oth		g Home 5 ☐ Res		□Other (Sn	ecify)
Attending Physician: r death. sctor: After this certific	runeral director,	=	27. Manner of Death	28a. Date of Injury (Month, Day, Year)	28b. Tin		28c. Injui Wor		28d. Describe			CONTY
ath.		atic	1 ☑ Natural 5 ☐ Pending 2 ☐ Accident investigation	on		M		Yes 2 □ No				
or Attend after death	<u>y</u>	Certification;	3 ☐ Suicide 6 ☐ Could not be determined		home, farm	n, street, factor	y, office			(Street and wn, State)	Number or F	Rural Route Number,
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the Hospital thin 24 hours a	completely filled in by the	ca	(Check only 2 Medical Exa	hysician: To the best of my k miner: On the basis of exami	nowledge, of	death occurre	d at the ti	me, date and pl	ace, and due to th	e cause(s)	and manner a	as stated.
To the I	mplet	Medical	une)	and manner stated.								
5 ₹ 5	8		29b. Signature and title of certifier	Ω	-	29	c. Licens	e number		29d. Date	signed (Mon	th, Day, Year)
			mer	- Elle	rol	<u>Q</u>	D 3	8262		Dece	mber 2	23, 2009
			30. Name and address of person who					и				1 00070
	Stat	0	Anurita Mendhirat 31. Date filed (Manth Day, Year)	ta, M.D., 240 32. Registrar's Sig	1 Rese	earch E	slvd.	, # 330	, Rockvi	lle,	Maryla	nd 20850
D.C.	Stat	e	31. Date filed (JAND) 8201	1 Burney	1 4	000						

DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

AMEND TEM# 1 per PHYS, G899, 17872010, WS
State of Maryland / Department of Health and Mental Hygiene Reg. No. 2009 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death A. Meeker Phyllis A. Month Day Year **Physician** 1443 Meeker 2009 /Medical 4a. Facility Name (If not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death Baltimore University of Maryland Center Medical 7. Age (In yrs. last birthday) If Under 1 Year | If Under 24 Hrs 8. Date of Birth (Month, Day, 9/22/35 5. Social Security Number Birthplace (State or Foreign Country) **Funeral** 297-28-9856 1 M XXF Months Days Hours Director OH Usual Residence of Decedent permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If tem 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Marical Examinar mass he resisted. 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits OH Erie Huron Yes 2 □ No Director 10e. Street and Number 10g. Citizen of What Country? 10f. Zip Code 210 글 Miami Place 44839 USA Funeral 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Bace - American Indian. 11. Marital Status Black, White, etc 1 ☐Yes 2 ☒ If Yes, Give Year or Dates: 1 Never Married 2 Married 2 XX Baltimore, Maryland 21215-0036 1 □Yes XX No Specify. þ white 3 Widowed 4 Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) 11 0 Bookkeeper Detention Home 17. Father's Name (First, Middle, Last) Harold Schenk 18. Mother's Name (First, Middle, Maiden Surname)
Marjorie Brant Be မ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Gerald Meeker $210\frac{1}{2}$ Miami Place, Huron OH 44839 20b. Place of Disposition (Name of cemetery, crematory or other place)
Meadow Green Memorial Park 20a. Method of Disposition 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Cremation 3 🖾 Removal from State 12/28/2009 Huron, 4 ☐ Donation 5 ☐ Other (Specify) Jæ Name and Address of Facility
Charles L. Stevens Funeral Home, Inc.
1501 East Fort Avenue, Baltimore MD 21230 SEuneral Service Licensee Victor P. Doda, ाप 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) **Physician** Brain ternication /Medical Due to (or as a consequence of) **Examiner** Hemorr hage Intra-cierebra Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Mussive Examine Due to (or as a consequence of) attending physician and for use as the burial-trar the Hospital or Attending Physician: The law requires that the death certificate be exect Due to (or as a consequence of) Division of Vital Records, P.O. Box 68760, Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? Month Day Year 4 ☐ Pregnant at time of death 5 Other (specify) ☐Yes 2 No 9 Unknown 9 Unknown signed by the Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ cate has been signated by page 2 should b 1 ☐ Yes 2 No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? certificate 2 □ No 1 □Yes 2 🔼 No 1 ☐ Yes this certific ral director, 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 \sum Nursing Home 5 \subseteq Residence 6 \subseteq Other (Specify) Certification: To 1 Tes 2 No 1XInpatient 2 ☐ ER/Outpatient 3 ☐ DOA 28a. Date of Injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? After 1 28d. Describe how injury occurred 1. Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No 24 hours after death, Funeral Director: # letely filled in by the fi 2 Accident 6 Could not be determined 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 24 hours 1 💆 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a, Certifier Medical completely (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. within 2 To the I 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 900 2009 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Crandal Battimore, MD <u></u>\, M.D. Kenneth

State Registrar 31. Date filed (Month, Day, Year)

32. Registrar's Signature

	1 - State Registrar	no /Eint Middle	(act)		(Certificate of	Death	2. Date of De	Reg. No	2009	3. Time of Death
an	Thon		*	Morri	ssey			Month De c	Z	2009	544 P
er	4a. Facility Name				~	4b. City, Town, o	or Location of De	ath		County of Dea	ith
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	5. Social Security I		1 □ M 2 □ F			rs. Months Days			ay, Year,) (ountry) rginia
	229-84- Usual Residence							Dec. 1	1, 1	. 7 . 7 . 7	
	10a. State	10b. County		10c	. City, Town	or Location					10d. Inside City Limit
Taller and the second	MD	Howar	d	I	Ellico	tt City					
	10e. Street and Nu					10f. Zip Code				itizen of What C	ountry :
		eed Lane	12. Was Dec	edent Ever i	in IIS	21042	Hispanic Origin?	(Specify Yes or N	US o-	14. Race - Am	erican Indian,
	11. Marital Status 1 □ Never Mar	rried 2 Marrie	Armed Fo	orces?		13. Was Decedent of If Yes, specify Cub		erto Rican, etc.)		Black, Whi	te, etc.
		4 Divorced	If Yes, Gi Year or E	ive Dates:		1 □Yes 2 13 No	Specify:			Specify: W	hite
	(Spe	15. Decedent's	Education grade completed))	1 1	Decedent's Usual Occu	during most of w	rorkina	16b. l	Kind of Business	/Industry
	Elementary/Sec		College (life. DO NOT use retire	ed)		Re	public	National
	47 5 10 10 11 11 11	(Final Middle 1	4	-	Sa	les Person	18 Mother's N	ame (First, Middle			ing Compan
	17. Father's Name							ed Teta	, waiso	n ourname,	
	James I	F. Morri			19h	Mailing Address (Stree	t and Number or	Rural Route Numi	ber. City	or Town, State,	Zip Code)
			issey-Br	other		641 Prince Virginia B	Phillip each. VA	Drive 23452			
	20a. Method of Di		IBBCy DI		0b. Place of	Disposition (Name of crematory or other pla	7	Date	20c. l	Location - City o	r Town, State
		Cremation 3 5 ☐ Other (Spe	3 ☐ Removal from ecify)	State	Prince Memori	ss Anne al Park	i	-2010	 Vir	ginia B	each, VA
	21 Signature of F					22. Name and Addr	ess of Facility	ollomon-			al Home -
/) ku	- De	ndl	\mathcal{Q}		3600 Virg	inia Rea	ch Blvd.	, Vi	irginia	Beach, FA
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09-09393 Ella Miller Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

.na winei		1- For State Certificate Certificate	it of Health and Mental H e <i>of Death</i>	lygiene Reg. No.	2009 4277
Physici				2. Date of Death	3. Time of Death
Medical Exami	iner	Ella Miller 4a. Facility Name (if not institution, give street and number)	4b. City, Town, or Location of Death	December 2, 2009	1148 hrs
		Good Samaritan Hospital	Baltimore	40. 000	nty of Death
Funeral Director		5. Social Security Number ank 6. Sex 1. M 2. XF 6.5	y) If Under 1 Year If Under 24Hrs Months Days Hours Min		YYY) 9. Birthplace (State or Unk Foreign Country)
any		Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or I	cocation		10d. Inside City Limits
A	'n	MD Bai	ltimore		1 Yes 2 No
Maryla 28a-f	Director	10e. Street and Number	10f. Zip Code		f What Country?
ith the 23a or notifie			21214		SA
D 21215-0036 should be filed within 72 hours after death with the Maryland and Mental Hygiene. 7 is marked other than "natural", or items 23a or 28a-f sho natic event, the Medical Examiner must be notified at once.	y Funeral		B. Was Decedent of Hispanic Origin? (S If Yes, specify Cuban, Mexican, Puerto Yes 2 X No specify:		tace - American Indian, Black, White, etc. black
5-0036 led within 72 hours after Hygiene. other than "natural", the Medical Examiner.	ed by	of Dates:	cedent's Usual Occupation (Give kind of ing most of working life. DO NOT use ret	work doneunk 16b. Kind o	f Business/Industry unk
36 in 72 h	Completed	Elementary/Secondary (0-12) College (1-4 or 5+)	ing most of working line. DO NOT use rec	ned)	
d with ygiene ygiene other t	Com	unk unk 17. Father's Name (First, Middle, Last)	unk 18.Mother's Name	e (First, Middle, Maiden Surna	ame) unk
21215-0036 2uld be filed within 7 Menial Hygiene, marked other than ic event, the Medica	Be		dik		unk
Baltimore, MD 21215 permit Pages I and 2 should be file Department of Fleath and Mental H, Important: If item 27 is marked o injury or other traumatic event, th	P	1	failing Address (Street and Number or	· ·	
e, MD and 2 sho Health and item 27 is		20a. Method of Disposition 20b. Place of D	11 Penn Street Bal isposition (Name of cemetery,		. 201 on - City or Town, State
MOF Pages 1 ent of 1 nt: If		1 Burial 2 Cremation 3 Removal from State crematory 4 Donation 5 A Other Specify: in State	or other place)		
Baltimore, permit Pages I a Department of He important: If ite			22. Name and Address of Facility State Anatomy Boar	rd 655 W. Balt	imore Street
		111111111111111111111111111111111111111	Baltimore, MD 212	201	The second secon
Physician /Medical		fallure. List only one cause on each line.		or respiratory arrest, snock, or	Approximate Interval Between Onset and Death
`xaminer		Immediate Cause (Final disease or condition resulting in death) a. Atherosclerotic Cardiovascular Due to (or as a consequence of):	Disease		
	<u> </u>	Sequentially list conditions, b.			
	Examiner	If any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated c			
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760, ficate be executed g physician and the burial - transit				23d. Dat	e of delivery
Box 687 e death certific the attending p ed for use as th	sician/	23b. Was decedent pregnant in the past 12 months? 1 Live birth 2 pregnant at time of death 5	Fetal death 3 Ectopic pregnation of the Company Specify)	nancy Mont	th Day Year
Box e death the atte	Physi	1 Yes 2 No 9 Unknown 9 Unknown	Other (Specify)		
Division of Vital Records, P.O. Box 68760, for the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial - transitions.	by P		the underlying cause given in Part I.		ontribute to the cause of death? 3 Probably 4 ✔ Unknown
ords, F v requires s been sign should be	ted				4b. Were autopsy findings available
COF	Completed			autopsy performed?	prior to completion of cause of death?
Division of Vital Records, To the Hospital or Attending Physician: The law requir within 24 hours after death. To the Funeral Director: After this certificate has been si completely filled in by the funeral director, page 2 should to			26.Place of Death (Check	1 Yes 2 No	1 Yes 2 No
Vita hysicia this cer	o Be		Othor	ng Home 5 Residence	6 Other:
Iing Pl	Ë	27. Manner of Death 1 Natural 5 Page inc. 28a. Date of Injury (Month, Day, Year) 28b. Time	e of Injury 28c. Injury at Work?	28d. Describe how injury oc	curred
IVISIOR or Attencafter death Director:	catio	Pending Accident Services Ser	1 Yes 2 No	29f Location (Street and No	umber or Rural Route Number, City
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Division To the Hospital or Attend within 24 hours after death To the Funeral Director:					
To the within To the compl	Medical	one) 2 Medical Examiner: On the basis of examination and/or investand manner stated.			
	2	29b. Signature and title of certifier	29c. License number O.C.M.E.		signed (Month, Day, Year) Der 3, 2009
	-	30. Name and address of person who completed cause of death (Item 23a)		20001112	
		Pamela E. Southall, MD Assistant Medical Examiner	111 Penn Street, Baltimore, I	MD 21201	
St Regist	w		30		
DHMH 17 Rev 1/2		ORIGI	IMAL		
OCME 2006		URIG	INAL	OCME	

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Bepartment of Health and Mental Hygiene For State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ OREC EARSO Medical Examiner 4b. City, Town, or Location of Death 4c. County of Death If Under 24 Hrs. Age (In yrs, last birthday) 8. Date of Birth **Funeral** 9. Birthplace (State or Forei Months Hours Min. Oct. 28, Director โ่ 930 South Carolina Usual Residence of Deceden item 27 is marked other than "natural", or items 23a or 28a-f show other traumatic event, the Medical Examiner must be notified at 10a. State 10b. County be filed within 72 hours after death with the Maryland 10c. City. Town or Location 10d. Inside City Limits Director mo Chevy Chase 1 X Yes 2 ☐ No 10e. Street and Numbe 10f. Zip Code 10g. Citizen of What Country? Funeral 4707 Chevy Chase Dr. #T4 20815 U.S.A. 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Armed Forces?
1 ☐ Yes 2 🔼 No Black, White, etc. Completed by 1 X Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify: If Yes, Give "natural", 3 Divorced Specify: Black Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed, (Give kind of work done during most of working life. DO NOT use retired) id Mental Hygiene. marked other than Elementary/Seconday (0-12) College (1-4 or 5+) Homemaker Own Home Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ဂ္ permit. Page 1 and 2 should be Department of Health and Men Important: If item 27 is marke any injury or other traumatic. Stanyard Pearson Navara Tinsley 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) LoJuana Faye Davis (Daughter) 2328 Nicol Circle, Bowie, MD 20721 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State 1 M Burial 2 Cremation 3 Removal from State cemetery, crematory or other place) Tod Homestead Cemetery12/30/09 4 Donation 5 Other (Specify) Youngstown, OH 21. Signature of uneral Service Lig Name and Address of Facility
E. Black-Phillips & Holden Funeral Home
51 McGuffey Rd., Youngstown, OH 44505 23a. Part 1. Enter the disease, or complications that caused the death. Approximate shock, or heart failure. List only one caus-Interval Between Immediate Cause (Final Physician. disease or condition resulting in death) Medical Due to (or as a consequence of) Examiner Sequentially list conditions if any, leading to immediate cause. Enter Underlying Cause (Disease or linjury To the Hospital or Attending Physician: The law requires that the death certificate be executed physician and s the burial-tran that initiated events 2 resulting in death) Last Due to (or as a consequence of): Physician/Medical Division of Vital Records, P.O. Box 68760 Str use as IF FEMALE: 23c. If yes, outcome of pregnancy 1 \square Live Birth 2 \square Fetal death 3 \square Ectopic pregnancy 23b. Was decedent pregnant 23d. Date of delivery in the past 12 months? ģ 5 Other (specify) Pregnant at time of death Month Year 9 Unknown signed by t d be detach Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 2 No 3 ☐ Probably 4 ☐ Unknown 1 🗌 Yes page 2 should 5 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy perform 1 ☐ Yes 2 ☐ No Yes 25. Was case referred to medical examiner?

1 Yes 2 No Be 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) မ 1 Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 28a. Date of injury (Month, Day, Year) 27. Manner of Death Certificate: 28b. Time of 28c. Injury at work? 28d. Describe how injury occurred 5 Pending ☐ Accident ☐ Sulcide 1 Yes 2 No Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined 24 hours Medical within 24 hou

To the Funel

completed fil 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Certifying Nurse Practionar: It this basi of my knowledge and consend at the time, date and place, and due to the cause(s) and manner stated. (Check only one 29b. Signatura D53367 int) SHYAM SUNDA SUINE: 117, SIMA who completed cause of death (Item 23a) (Type, Print) 31. Date filed (Month, Day, State JAN 0 8 201 Registrar

DHMH 17 Rev 7/2009

Division or Vital Records, P.O. Box 68760, To the Hospital or Attending Physician: 24 hours a within 24 hou

To the Fune

completely file

Baltimore, Maryland 21215-0036

State Registrar 29b. Signature and title of certifier

SHOALLS A. HASHMI MD 821 N. EUTAW ST Juile 305 31. Date filed (Month, Day, Year) 32. Registrar's Signature JAN 08 2010

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

and manner stated.

MD

29c. License number

D 31464

29d. Date signed (Month, Day, Year)

21201

01106

BALTIMORE MD

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

Amend #30 per DVR 8899 1/8/10 TT

Amend #30 per DVR 8899 1/8/10 TT

Amend #30 per DVR 8899 1/8/10 TT

		-	For State of State of Registrar	Maryland / Deb <i>Ce</i>	ertificate of L		ientai Hyg	eg. No. 20	09	42773
	Physicia	ın	1. Decedent's Name (First, Middle, Last) Farry	,			2. Date of Deat Month	Day	Year	3. Time of Death 1:30 AM M
	/Medic Examin		4a. Facility Name (If not institution, give street and numi		4b. City, Town, or	Location of Death	Decembe	4c. County		1:30 AM
	LXaiiiii	Ęι	Laurel Regional Hospit	al	Laurel			Princ	e Geo	rge's
	Funeral Director		1 X M 2 □ F	Age (In yrs. last birthday 61 Yrs.	Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day) Aug 9,		9. Birthpl Coun	ace (State or Foreign try) unk
	and		Usual Residence of Decedent 10a. State 10b. County	10c. City, Town or L	ocation				10	Od. Inside City Limits
	Maryl -f sho	tor	PA	Pit	tsburgh					1 □Yes 2 No
	with the	Director	10e. Street and Number P.O. Box 16471		10f. Zip Code	15242	1	0g. Citizen of W	Vhat Coun	try?
(0	be filed within 72 hours after death with the Maryland ital Hyglene. ad other than "natural", or items 23a or 28a-f show event, the Medical Evan in er unto princified at	Funeral	11. Marital Status 12. Was Deced Armed Forc	X No	. Was Decedent of H If Yes, specify Cuba	ispanic Origin? (Sp n, Mexican, Puerto	ecify Yes or No- Rican, etc.)	14. Race Blace	e - Americ ck, White, e	etc.
-003	hours a	ed by	3 ☐ Widowed 4 ☐ Divorced If Yes, Give Year or Date 15. Decedent's Education	es: 16a. Dec	1 ☐ Yes 2X No edent's Usual Occup.	Specify:	un	Specify 16b. Kind of Bu		lack lustry unk
1215	within 72 lene. than "na	Completed	(Specify only highest grade completed) Elementary/Secondary (0-12) unk College (1-4)	(Giv	e kind of work done o DO NOT use retired	luring most of work	ing			
altimore, Maryland 21215-0036		To Be C	17. Father's Name (First, Middle, Last)		unk	18. Mother's Name	e (First, Middle,	Maiden Surnam	ne)	unk
aryl	12 should be f h and Mental I 7 is marked of traumatic eve	Ĕ	19a. Informant's Name/Relationship (Type. Print)	19b. Mai	ling Address (Street	and Number or Rur	al Route Numbe	r, City or Town,	State, Zip	Code)
Z,	and 2 lealth in m 27 i		Trina Bryant/daughter		5 W. McDov		#3070 E	hoenix,		
imore	permit. Pages 1 and 2 should be Department of Health and Menta Important: If item 27 is marked any injury or other traumatic es once.		20a. Method of Disposition 1 □ Burial 2 □ Cremation 3 □ Removal from S 4 □ Donation 5 ② Other (Specify) in St	ate	position (Name of ematory or other plac					
Balt	permit. Depart Import any Inj		21. Signal of Funeral Service Licensee Ron of Swarps,		_{22. Name and Addre} State Anat Baltimore,	MD 2120)1		ore S	Street
			23a. Part I. Enter the disease, or complications that ca shock, or heart failure. List only one cause on ea	used the death. Do not e ch line.	nter the mode of dyir	ng, such as cardiac	or respiratory ar	rest,		Approximate Interval Between Onset and Death
	Physician /Medical		resulting in death)	cancer of li	lver				-	
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	ficate be executed physician and s the burial-transit	Examiner	that initiated events c.	r as a consequence of):						
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O. Box	he death certificate be executed r the attending physician and ched for use as the burial-transit	Physician/M	23b. Was decedent pregnant in the past 12 months?	ant at time of death 5	B ☐ Ectopic pregnanc □ Other (<i>specify</i>) _	у			ite of delive onth	ery Day Year
σ.	uires that the de signed by the id be detached	þ	Part II. Other significant conditions contributing to dea	nth but not resulting in the	underlying cause giv	en in Part I.		obacco use cont es 2 No		ne cause of death?
of Vital Records,	The law requires that the ate has been signed by the bage 2 should be detache	Completed				·	24a. Was a autop perfor	sy med?	Were auto prior to co death? 1 ☐ Yes	psy findings available mpletion of cause of
ital	yslcian: The is certificate h director, page	Be C	25. Was case referred to medical			26. Place of Dea	1 ☐ Yes th (Check only o		I Lles	2 🗆 110
>	Physici this ce al direc			patient 2 ER/Outpati		4 LI Nursing H	ome 5 Resid			(y)
o uc	Attending Physician: r death. ector: After this certifice by the funeral director, p	ion:	Tending	f Injury , <i>Day, Year)</i> 28b. Time Injury	/ Wor	yat k? Yes 2∐No	28d. Describe h	ow injury occur	red	
Division	or Attendatter deatt Director: In by the	Certification: To	3 ☐ Suicide 6 ☐ Could not be 28e. Place	of Injury - At home, farm, s g, etc. <i>(Specify)</i>			28f. Location (S City or To w	Street and Numb In, State)	ber or Rura	al Route Number,
_	To the Hospital or Attenwithin 24 hours after deatl To the Funeral Director:	Medical Co	29a. Certifier (Check only one) 1 ☐ Certifying Physician: To the 2 ☐ Medical Examiner: On the base and mann	sis of examination and/or						
	To the within To the compli	Me	29b. Signature and title of certifier Muln	I MP.	29c. Licens			29d. Date signe		
			30. Name and address of person who completed cause	of death (Item 23a) (Type		4283		Dec 30	, 200	J9
			Muhammad Yusuf, MD 13631			aurel, M	20707			
	Sta Regist		31 Date filed (Month Day Year) 32. Re	strar's Signature	_					
	riegist	Carl C	Sun A O COIA	Not to	7					

Amend #1, Please Type or Print in Black Indelible Ink, Ensure All Copies Are Legible. 10b, 10d, 10e per Fn g899 1/8/10 TT State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 2 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death ROOKS Philip Rooks, Sr. Physician/ Month December 05: 24 AM 2009 Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** 4c. County of Death HARBOR HOSPITAL BALTIMORE 5. Social Security Number 6 Sex If Under 1 Year If Under 24 Hrs. 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year, **Funeral** 9. Birthplace (State or Foreign 1 X M 2 | F Months Days Hours Min. Country) Director 220-18-5017 84 6-20-1925 MD Usual Residence of Decedent show Anne Arundel or 28a-f show notified at be filed within 72 hours after death with the Maryland 10a. State 10c. City, Town or Location 10d. Inside City Limits Director 1 √es 2 No -Baltimore Glen Burnie MD 10e. Street and Number 10f. Zip Code ò 10g. Citizen of What Country? ed other than "natural", or items 23a o event, the Medical Examiner must be Funeral **Hollins** 21061 U.S.A. Hollin <u>Ferry Rd</u> N 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-11. Marital Status 14. Race - American Indian Armed Forces?

1 Yes 2 No
If Yes, Give If Yes, specify Cuban, Mexican, Puerto Rican, etc. Black. White, etc. þ 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify: Specify: Black Completed 3 Widowed 4 Divorced Year or Dates. 1943-46 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business Industry
Board of Education (Give kind of work done during most of working al Hygiene. life, DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) New York City Machinist <u>12th grade</u> Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) and Mental Fis marked o permit. Page 1 and 2 should be 1 Department of Health and Mental Important: If item 27 is medany injury or other 2 မ Violet Marie Hines James Orsie Rooks 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Hollins Ferry Rd, GlenBurnie, Md 21061 105 N. Paula Rooks-Daughter
20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Date 1 🗆 Burial 2 🕱 Cremation 3 🗀 Removal from State 4 Donation 5 Other (Specify) Crematory 12/29/09 Baltimore, Md 22. Name and Address of Facility March F/H West ture of Funeral Service Licensee 21. Sign 4300 Wabash Ave. Baltimore, MD 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart rejure. List only one cause on each line. Approximate interval Between Onset and Death Immediate Cause (Final Complication of Physician/ small bowel abstruction disease or condition resulting in death) Medical Due to (or as a consequence of) Examiner Sequentially list conditions Examine if any, leading to immediate cause. Enter Underlying Due to (or as a consequence of): attending physician and for use as the burial-transit Cause (Disease or iiniun that initiated events resulting in death) Last Due to (or as a consequence of) Physician/Medical Division of Vital Records, P.O. Box 68760 23c. If yes, outcome of pregnancy

1 Live Birth 2 Fetal death 3 Ectopic pregnancy

5 Other (specify) IF FEMALE 23b. Was decedent pregnant 23d. Date of delivery in the past 12 months?
1 Yes 2 No Month Year Day 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 2 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☑ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an autopsy perform Yes 2 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Hospital: Other: 2 No ည 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of Certificate: 28c. Injury at work? 28d. Describe how injury occurred the Hospital or Attending 1 Natural injury 5 Pending 1 Yes 2 No 2 Accident
3 Suicide Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, determined City or Town, State) within 24 hours a

To the Funeral C Medical 29a. Certifier 1 Vertifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner. On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 3 Certifying Nurse Practioner. To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) Resident RES- 00 1 ()arra December, 26, 2009 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)
3001 HANOVER STREET, HARBOR HOSPITAL 31. Date filed (Month, Day, Year) State A post Registrar JAN 0 8 2010

DHMH 17 Rev 7/2009

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month Day

DECEMBER 30, 2009 JAMES ERNEST SEGRAVES 7:50 A 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Harford Nichols Edgewood Senior Care If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Feb. 2, 9. Birthplace (State or Foreign Country) North Carolina 5. Social Security Number 7. Age (In yrs. last birthday) Months Days Min. Hours 1 XM 2 □ F Yrs 1918 Feb. 218-26-4363 Usual Residence of Decedent 10a. State 10h County 10c. City, Town or Location 10d. Inside City Limits 1 □Yes 2 ZNo Maryland | Harford Edgewood 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code USA 21040 1111 D Hanson Road 12. Was Decedent Ever in U.S. Armed Forces? 1 ⊠Yes 2 □ No If Yes, Give Year or Dates: 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 ☐ Never Married 2 ☐ Married 1 ☐Yes 2 No Specify. Specify: 3 ₩idowed 4 Divorced White 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Security Company 12 Security Guard 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Lura Z. Blevins Antone Ward Segraves 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Regina Nacrelli / Niece 20a. Method of Disposition 541 Christina Dr., St. Augustine, FL 32086 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State Hilltop Service Corp: 1/4/2010 Towson, Maryland ion 5 □ Other (*Specify*)
Funer(/Service Licensee 4 Donation 22. Name and Address of Facility McComas Funeral Home, P.A. 1317 Cokesbury Road, Abingdon, Maryland 21009 23a. Part 1. Enter the disease, or complicators that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Atherosclerotic cardiovascular disease disease or condition resulting in death) Due to (or as a consequence of): Hyper tension
Due to (bras a consequence of): Sep513 Due to (or as a consequence of) 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Year Month Day 5 Other (specify) 9 Unknown 23e. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown Dementia 24a. Was an 24b. Were autopsy findings available prior to completion of cause of death? autopsy performed 2**X** No 2 🗆 No 1 □ Yes 1 ☐ Yes 25. Was case referred to medical 26. Place of Death (Check only one) 1∐Yes 2XNo

Physician /Medical Examiner

> and burial-trar

attending physician for use as the burla

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certificate

After this

after death

within 24 hours a To the Funeral L Hospital

or Attending

the

funeral director.

filled in by

law requires that the death certificate be executed

P.O. Box 68760,

Division of Vital Records,

Physician

/Medical

Examiner

Director

Funeral

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Completed

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Certification: To

Medical

Funeral

Director

filed within 72 hours after death with the Maryland

Maryland 21215-0036

Baltimore,

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryla Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Machael Examiner must be notified at once.

if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last IF FEMALE:

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 28a. Date of Injury (Month, Day, Year) 28b. Time of 28c. Injury at Work?

Other: 4 Nursing Home 5 Residence Stother (Specify) Assisted 28d. Describe how injury occurred Living

27. Manner of Death 1 Natural 5 Pending 2 Accident investigation

6 Could not be determined 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

1 ☐ Yes 2 ☐ No 28f. Location (Street and Number or Rural Route Number, City or Town, State)

4 Homicide 29a. Certifier

3 Suicide

(Check only

l 🗶 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

one) 29b. Signature and title of certifier

31. Date filed (Month, Day, Year)

30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Stephanie

- MD DOUGH3909 December 30, 2009

ath (Item 23a) (Type, Print)

902 Averill Rd Joppa, MD 21085 Linder

State Registrar

rance



DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.
State of Maryland / Department of Health and Mental Hygiene 2009 Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day Year **Physician** IBRIHIM, TEJAN, SAVAGE 16:03 PM DEC 2009 /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death Examiner BALTIMORE UNIVERSITY OF MARYLAND MEDICAL CENTER If Under 1 Year | If Under 24 Hrs. 9. Birthplace (State or Foreign 5. Social Security Number 6. Sex 7. Age (In vrs. last birthday) 8. Date of Birth (Month, Day, **Funeral** 1 √ M 2 □ F Dec 21, Maryland Director infant Usual Residence of Decedent 10b. County 10c. City, Town or Location 10d. Inside City Limits show r than "natural", or items 23a or 28a-f show the Medical Evaniner must be notified at 1 ☐ Yes 2X☐ No Director Upper Marlboro Prince George's MD 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 20722 USA 12613 Marlton Center Drive Funeral Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 11 Marital Status hours after 1 X Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify: black þ 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry 72 Elementary/Secondary (0-12) College (1-4or 5+) infant infant infant h and Mental Hygie infant 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Brima Tejan Savage Giah Savage 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) permit. Pages 1 and 2 s
Department of Health ar
Important; if item 27 is
any injury or other trau University of MD Med Ctr Brima Tejan Savage/ Father 12613 Mariton Center Dr. Upper Mariboro, Md. 20772

Principaliting (Name of Date 20c. Location - City or Town, State 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4□Donation 5▼Other (Specify) in state 21. Sign ture of Soneral Service licensee Wade, Mrector State Anatomy Board 655 W. Baltimore Street Baltimore, MD 21201 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, wheart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** disease or condition resulting in death) CARDIAC FAILURE /Medical Due to (or as a consequence of): Examiner SEVERE RIGHT HEART FAILURE Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of). Examiner death certificate be executed physician and s the burial-trans that initiated events resulting in death) Last Due to (or as a consequence of): Box 68760 Physician/Medical as IF FEMALE: 23c. If ves. outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant 1 ☐ Live birth 2 ☐ Fetal death 4 ☐ Pregnant at time of death 9 ☐ Unknown 3 Ectopic pregnancy in the past 12 mopths? Month Day Year 5 Other (specify) 1 □ Yes 2 □ No o 9 Unknown σ. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, Completed by g g 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? 2 No 2 1 No 1 PYes 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 ☑ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To To the Hospital or Attending Phys within 24 hours after death.

To the Funeral Director; After this completely filled in by the funeral dir this 28a. Date of Injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 5 Pending investigation 1 Natural 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical (Check only one) and manner stated. 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) Dec, 21,2009 , MD Paaaa5 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) BALTIMORE, MD 21201 KAVITHA KONDURU, 295 GREENE ST,

DHMH 17 Rev 1/2001

State Registrar 31. Date filed (Month, Day, Year)

09-10151 Raynard Stancil		Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene	
<u> </u>		1- For State Certificate of Death Reg. No. 2009	4277
Physicia Medical Examir		Month Day Year	ime of Death 1936 hrs
		4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death Johns Hopkins Hospital 4c. County of Death Baltimore	
Funeral Director		5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) If Under 1 Year If Under 24Hrs. 8. Date of Birth(MM/DD/YYYY) 9. Birthplact Foreign	
		Usual Residence of Decedent	
ld frow any			I. Inside City Limits Yes 2 No
death with the Maryland or items 23a or 28a-f show	Director	10e. Street and Number 10f. Zip Code 10g. Citizen of What Country?	2
with the ns 23a o	eral D	11. Marital Status / 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-	<u> </u>
	뒤	1 Never Married 2 Married Armed Forces? 1 Yes 2 No 3 Widowed 4 Divorced If Yes, Give Year 1 Yes 2 No specify:	1
2 hours after d "natural", or Examiner m	ed by	or Dates:	
5-0036 led within 72 Hygiene, other than "	Completed	Elementary/Secondary (0-12) College (1-4 or 5+) UKN Car U	Jash
21215-00; uld be filed with Mental Hygiene marked other t	Be Co	17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Syrname) 18. Mother's Name (First, Middle, Maiden Syrname) Share Addison	
ID 2121 should be fi and Mental 77 is marked	1	19a. Informant's Name/Relationship (Type, Print) wife 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zipe Contant of Ave. Backs Ma	Code) 2/2/3
md 2	1	20a. Method of Disposition 1 V Burial 2 Cremation 3 Removal from State 20b. Place of Disposition (Name of cemetery) 20c. Location - City or Town crematory or other place)	
Baltimore Department of Hi Important: If it		4 Dophation 5 Other Specify: Mf Carmel Cemelery 12010 Balto- Mil	hapel
Balti permit. Departi Import injury		1434 N. Beradway Baito. Md.	21213
Physician Identical			oproximate Interval etween Onset and Death
Examiner		or condition resulting in death) Due to (or as a consequence of):	
	iner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause	
ecuted and transit	Examiner	(Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of):	
	dical	Xunpended 23a,27,perME, g899 1/11/10 TT	
68760, certificate be nding physic		IF FEMALE: 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 3 Ectopic pregnancy Month Day	Year
Box (e death ce the attence ed for use	hysici	1 Yes 2 No 9 Unknown 9 Unknown 9 Unknown 9 Unknown 10 Other (Specify)	0
of Vital Records, P.O. Box 68760, ing Physician: The law requires that the death certificate be ex After this certificate has been signed by the attending physician tumeral director, page 2 should be detached for use as the burial	by P	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the ca	-
ords, w require s been si should b	Completed		findings available etion of cause of
of Vital Records, ag Physician: The law requir. Wher this certificate has been someral director, page 2 should land.		performed? 1 ✓ Yes 2 No 1 ✓ Yes 25. Was case referred to medical 26 Place of Death (Check only one)	2 No
Vital hysician this cert	To Be	examiner? 1 ✓ Yes 2 No Hospital: 1 Inpatient 2 ✓ ER/Outpatient 3 DOA Other Nursing Home 5 Residence 6 Other.	
on of Ninding Physics After the funeral		27. Manner of Death 1 X Natural 5 Pending 28a. Date of Injury (Month, Day,Year) 28b. Time of Injury 28c. Injury at Work? 1 Yes 2 No	
Division Division ppiral or Attendir cours after death.	Certification:	2 Accident Investigation 3 Suicide 6 Could not be determined (Specify) 28e Place of Injury - At home, farm, street, factory, office building, etc. or Town, State) 28f. Location (Street and Number or Rural Roor or Town, State)	oute Number, City
Division of Vital Records, P.O. Box 68760, To the Hospital or Attending Physician: The law requires that the death certificate be exwithin 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician completely filled in by the funeral director, page 2 should be detached for use as the burial	Medical Ce	4 Homicide determined (Specify) 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. One) 2 W Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)	use(s)
To To com	Mec	29b Signature and title of certifier 29c. License number 29d. Date signed (Month, D	Pay, Year)
		30. Name and address of person who completed cause of death (Item 23a)	
		Laron Locke MD. Assistant Medical Examiner 111 Penn Street, Baltimore, MD 21201	
Sta Regist			

DHMH 17 Rev 1/2001 OCME 2006 OCME

ORIGINAL

09-09797 Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. 2009 42778 State of Maryland / Department of Health and Mental Hygiene James Albert Stratemeyer 1- For State Certificate of Death Reg. No Registrar

1. Decedent's Name (First, Middle,Last) 2. Date of Death 3. Time of Death Physician/ Month Day Year December 16, 2009 2321 hrs **Medical Examiner** James Albert Stratemeyer 4a. Facility Name (if not institution, give street and number) c. County of Death 4b. City, Town, or Location of Death **Baltimore County** 8511 Chestnut Oak Road Parkville 5. Social Security Number unk 6. Sex 8. Date of Birth (MM/DD/YYYY) 9. Birthplace (State or Foreign 7. Age (In yrs. last birthday) If Under 1 Year | If Under 24Hrs. **Funeral** Country) Months Davs Hours Min. Director 56 Aug 10, 1953 Maryland Usual Residence of Deceden 10d. Inside City Limits 10a State 10b County 10c. City, Town or Location 1 Yes 2 V No MD 28a-f show Baltimore Parkville or items 23a or 28a-f shore. must be notified at once. hours after death with the Maryland 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 8511 Chestnut Oak Road 21234 USA 13. Was Decedent of Hispanic Origin? (Specify Yes or No-14. Race - American Indian, Black, Funeral 11. Marital Status 12. Was Decedent Ever in U.S. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) White, etc. Armed Forces? Never Married Married 2 X No Yes Yes 2 X No specify: 3 X Widowed Divorced If Yes, Give Year Specify white marked other than "natural", event, the Medical Examiner þ 16a. Decedent's Usual Occupation (Give kind of work done 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Completed during most of working life. DO NOT use retired) Pages 1 and 2 should be filed within 72 1 nent of Health and Mental Hygiene ant: If item 27 is marked other than "n Elementary/Secondary (0-12) College (1-4 or 5+) Baltimore, MD 21215-0036 book writer journalism 17. Father's Name (First, Middle, Last) 18 Mother's Name (First, Middle, Maiden Surname) Harry Theodore Stratemeyer Be Christine Carl 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Harry T. Stratemeyer/nephew 10104 Woodlake Drive Cockeysville, MD 21030 20b. Place of Disposition (Name of cemetery, 20a, Method of Disposition Date 20c. Location - City or Town, State Important: If it crematory or other place) Cremation 3 Removal from State 5 X Other Specify: 21. Signature of Funeral Strvice Licensee Ranald S. 22. Name and Address of Facility STate Anatomy Board 655 W. Baltimore Street Baltimore, MD 212-1 rt I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart Approximate Interval **Physician** faiture. List only one cause on each line /Medical Death Hypertensive atherosclerotic cardiovascular disease Immediate Cause (Final disease xamine or condition resulting in death) Due to (or as a consequence of): Sequentially list conditions, If any, leading to immediate cause. Enter Underlying Cause Due to (or as a consequence of): Examine (Disease or injury that initiated Due to (or as a consequence of): events resulting in death) Last and Physician/Medical X UNPENDED AMENDED ending physician 23a, PII, 27, permE, g899 1/11/10 TT Box 68760 23d. Date of delivery IF FEMALE 23c. If yes, outcome of pregnancy 23b. Was decedent pregnant in the 3 Ectopic pregnancy Day Year Live birth Fetal death past 12 months? Pregnant at time of death Other (Specify) the at Yes 2 No 9 Unknown signed by the at he detached for Unknown by 1 ⋧ Completed

the Hospital or Attending Physician: The law requires that the death certificate be executed Division of Vital Records, P.O. has been oage certificate this After hours after death. Director: the To the Funeral

Be

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Certification:

Medical

Part II. Other significant conditions	 contributing to death but no 	t resulting in the underlyi	ng cause given in Part I.	23e. Did tobacco us	e contribute to the cause of death?
Obesity				1 Yes 2	No 3 Probably 4 V Unknown
				24a. Was an autopsy performed?	24b. Were autopsy findings available prior to completion of cause of death? 1 Yes 2 No
25. Was case referred to medical			26.Place of Death (Chec	k only one)	
examiner? 1 ✓ Yes 2 No	Hospital: 1 Inpatient 2	ER/Outpatient 3	DOA Other Nurs	ing Home 5 Residence	te 6 🗸 Other: Scene
27. Manner of Death	28a. Date of Injury	28b. Time of Injury	28c. Injury at Work?	28d. Describe how injury	occurred
1 X Natural 5 Pending 2 Accident Investigal	(Month, Day,Year)		1 Yes 2 No		
3 Suicide 6 Could no	be 28e. Place of Injury - A	t home, farm, street, facto	ory, office building, etc.	28f. Location (Street and or Town, State)	i Number or Rural Route Number, Cit
4 Hemicide determine	ed (Specify)				

29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 29b. Signature and titls of certifie 29c. License number 29d. Date signed (Month, Day, Year) O.C.M.E December 17, 2009

rassel d address of person who comple ed cause of death (Item 23a) 30. Name Melissa Brassell, MD

111 Penn Street, Baltimore, MD 21201

State Registra

Homicide

32. Registrar's Sig

Assistant Medical Examiner

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

		-	For State Registrar	State of M	aryland / De		ment of H icate of L		ı	Reg. No. 2	nna	1,2779
	Physicia	an.	1. Decedent's Name (First, Middle, I	•			-		2. Date of Dea Month Decemb	ath Cay	Year	3. Time of Death
	/Medic		William Simps						Decemb			1:57 AM ^M
	Examin	er	4a. Facility Name (If not institution, g			4b	o. City, Town, or ${ m E}1{ m kto}$	Location of Death			nty of Death	
M. A. S. C.			Union Hospita 5. Social Security Number 6		ge (In yrs. last birth	day) If	Under 1 Year	If Under 24 Hrs.	8. Date of Birl			lace (State or Foreign
t	Funeral Director		294-54-0306	1 X M 2 □ F	56 Yr	I M	onths Days	Hours Min.	8. Date of Bird (Month, Da Oct 9,	y, Year) 1953	Oh:	lace (State or Foreign try) Lo
	and		Usual Residence of Decedent 10a. State 10b. County		10c. City, Town of	or Location	on				1	0d. Inside City Limits
	Aaryl f sho	ō	MD Ceci	1	E1k	ton						1 □ Yes 2√ No
	the 128a-	rec	10e. Street and Number				10f. Zip Code			10g. Citizen	of What Cour	itry?
	3a or	Funeral Director	1747 West Pulas	ki Hgwv #9				21921		USA	Δ	
	death ms 2	ner	11. Marital Status	12. Was Decedent Armed Forces	Ever in U.S.	13. Was	Decedent of H	ispanic Origin? (Span, Mexican, Puerto	pecify Yes or No		Race - Americ Black, White,	
21215-0036	ges 1 and 2 should be filed within 72 hours after death with the Maryland to f Health and Mental Hygiene. If item 27 is marked other than "natural", or items 23a or 28a-f show or other traumatic event, the Medical Evantiver rust be recitified at	by	1 ☐ Never Married 2 ☐ Married 3 ☐ Widowed 4 ☒ Divorced		No		Yes 2∏No	Specify:	Trioun, oto.,			ite
0-10	2 hou	Completed	15. Decedent's (Specify only highest	Education	16a. D	Decedent	t's Usual Occup	ation during most of work	cina .	16b. Kind o	f Business/In	dustry
215	within 7 iene. • than "r	nple	Elementary/Secondary (0-12)	College (1-4or		life. DO	NOT use retired	d)	ang			
21	e filed within al Hygiene. I other than ' went, tre Me	Sol	9	0			mechan:		(PT		omotiv	
Maryland	be file	Be	17. Father's Name (First, Middle, La William Simpso					18. Mother's Nam	ie (First, Middie,	. Maiden Suri	name)	unk
3	2 should be and Mental is marked o	ပ္	-		10h l	Mailina A	ddroos /Stroot	and Number or Ru	ral Pauta Numb	er City or To	wn Stata Zir	Code)
Mai	d 2 sk th and 7 Is r traur		19a. Informant's Name/Relationship Paul Simpson/c				,	Road E1		· -	`	, code)
	1 and Health tem 27		20a. Method of Disposition	Ous III	20b. Place of D				Date Date		on - City or To	wn, State
altimore,	Pages nent of ant; If its ary or o		1 ☐ Burial 2 ☐ Cremation 3 4 ☐ Donation 5 ※ Other (See	□Removal from State		cremato	ory or other plac	ce) ;				
Balt	permit. Pages Department of Important; If i any injury or once.		21. Signature of suneral Service in Ronald S	Wade, Vi	ectar	Sta Bal	ame and Addre te Anat timore.	ss of Facility Omy Board MD 2120	1 655 W.	Balti	imore S	Street
			23a. Part 1 Enter the disease, or co shock or heart failure. List or	omplications that cause	d the death. Do no							Approximate Interval Between
Su	Physician		Immediate C se (Final disease or con tion	Circ	hona	CI.	live	_			1	Onset and Death
	/Medical		resulting in death)	Due to for as	a consequence of): (0	1				
	Examiner		Sequentially list conditions,	b. He	potrh	J				_		
	ed sit	ine	cause. Enter Underlying Cause (Disease or injury	Due to (or the	a consequence of	1:	limi					
	xecuti and I-trans	Examiner	that initiated events resulting in death) Last	c. Due to (or as	a consequence of	y 1	liver					
68760,	ficate be executed g physician and is the burial-transit	alE			(50	,-						
387	ficate phys s the	edical		d	10.							
Box (N/M	IF FEMALE: 23b. Was decedent pregnant	23c. If yes, outcome						23d	. Date of deliv	ery
	0 0	Physician/M	in the past 12 months? 1 ☐ Yes 2 ☐ No	4 ☐ Pregnant	2 ☐ Fetal death at time of death		ctopic pregnanc ther <i>(specify)</i> _	;y 			Month	Day Year
P.0.	that the deneed by the a	hys	9 Unknown	9 🗆 Unknown		-						
of Vital Records, I	es pegii	by	Part II. Other significant condition	s contributing to death	but not resulting in t	the unde	rlying cause giv	en in Part I.	23e. Did	5.6	s 2 No 3 Probably 4 Unknown	
S	~ III	Completed							24a. Was		4b. Were aut	opsy findings available
æ	• <u>-</u> <u>-</u>	mo							auto perfo 1 □ Yes	psy ormed? 2 XNo	death?	ompletion of cause of
ţ		(a)	25. Was case referred to medical	I.				26. Place of Dea		/	1 103	
	di is	OB	examiner? 1 ☐ Yes 2 No	Hospital: 1 Inpat	tient 2 ER/Outp	patient	3 □ DOA Oth	ner: 4 🗆 Nursing H	lome 5 Res	idence 6	Other (Spec	ffy)
o uo	on (fte	tion:	27. Manner of Death 1 Natural 5 Pending 2 Accident investiga	28a. Date of In (Month, D	jury 28b. Ti lay, Year) Inj	me of jury	28c. Injui Wor M 1 🗆	ry at k? ÌYes 2 □ No	28d. Describe	e how injury occurred		
Division	or Atten after deat Director: in by the	Certification:	3 ☐ Suicide 6 ☐ Could no determin	ad 286. Flace of II	njury - At home, farr tc. (Specify)	m, street	, factory, office		28f. Location (City or To	(Street and N wn, State)	umber or Rui	al Route Number,
_	To the Hospital or Attendi within 24 hours after death. To the Funeral Director: A completely filled in by the fi		(Check only 2 Medical E	Physician: To the bes	of examination and							
	thin 2 thin 2 the I	Medical	one) 29b. Signature and title of certifier	and manner s	stated.		29c. Licens	se number		29d. Date s	igned (Month	Day, Year)
	5 . ¥ 6 8	_	255. Signature and title of certifier	-au			-	- 0 -	6	1	1	
			30. Name and address of person v	no completed cause of	death (Item 23a) (1	Type, Pri	nt)	16075 J Main	C-i	CII.	(-	,
			Usden 7	oksoys	trario Siantina	2	23 U	J Man) 37.	C161	07,1	rr
	Sta Regist		31. Date filed JAN 08 20	10 Arreys	trar's Signature	and the						

DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Manyland / Department of Health and Mental Hygiene

Description Management Description Head (First Meditalizer) Joseph Albert Seenz Description Head (First Meditalizer) Joseph Albert Seenz Description Head (First Meditalizer) Description Head (First M	oocpii / libert C	, acii	State of Maryland / Department of He 1- For State Certificate of De Registrar Certificate		Reg. No. 2000	1,278
## FEBRUAY PARTIES IN THE PROPERTY AND T			Decedent's Name (First, Middle,Last)			
District Dis	Medical Exam	iner				520 hrs
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The content of the			018-46-1366 1XM 2F 57 Yrs.		Foreign	•
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State 31. Date filed (Month Day Year) 32. Registrar's Signature				altimore, MD 21201		
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DHMH 17 Rev 1/2001 OCME 2006

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 1^{Month} 2009 1:19 pM Clara Truesdale 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death Prince Georges Prince Georges Hospital Cheverly 8. Date of Birth (Month, Day, Year) 09/12/1922 Birthplace (State or Foreign Country) If Under 1 Year | If Under 24 Hrs. Social Security Number 6. Sex 7. Age (In yrs. last birthday) 1 □ M 2 🛛 F Months Days Hours Min. Yrs. 87 South Carolina 248-60-5792 Usual Residence of Decedent 10d. Inside City Limits 10c. City. Town or Location 10b. County 1 XYes 2 No Prince Georges District Heights 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Foster St. 20747 USA 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes ※☐ No If Yes, Give Year or Dates: 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14 Race - American Indian 11. Marital Status Black, White, etc. 1 ☐ Never Married 2 ☐ Married 1 ☐ Yes 2 🕱 No Specify. Specify: Black 3 Widowed 4 □ Divorced 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) 11 Dry Cleaners Presser 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Hamp Sloane Annie Sloane 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 6315 Foster St., District Heights, MD20747 Elnora T. Pearson/ Daughter 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 ☐ Burial 2XX remation 3 ☐ Removal from State Riverdale Park Cre. 1/05/10 Riverdale, MD 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility 21. Signature of Funeral Service Licenses Universal Mortuary Inc. nacew 411 Kennedy St NW, Washington, DC 20011 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Coronary Artery Disease Due to (or as a consequence of): Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Due to (or as a consequence of):

Physician) /Medical Examiner

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?7 is marked other than "natural", or items 23a or 28a-f show traumatic event, the Medical Examine must be positived at

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12 should be filed within 7 in and Mental Hygiene. 7 is marked other than "r

permit. Pages 1 and 2 should be Department of Health and Menta Important: If Item 27 is marked of any injury or other traumatic aw

Baltimore, Maryland 21215-0036

Examiner burial-trar Physician/Medical

and attending physician for use as the burial cate has been signed by the page 2 should be detached Completed by certificate After this certific funeral director, Be Certification: To within 24 hours after death.

To the Funeral Director: A completely filled in by the fu

law requires that the death certificate be executed

Hospital or Attending Physician:

Division of Vital Records, P.O. Box 68760,

	□ d							
IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1	s decedent pregnant 23c. If yes, outcome of pregnancy 1							
Part II. Other significant conditions	g to comment of the c	co use contribute to the cause of death? 2 □ No 3 □ Probably 4又 Unknown						
	24a. Was an autopsy performe 1 □ Yes 2 E							
25. Was case referred to medical	26. Place of Death (Check only one)							
examiner? 1 ☐ Yes 2 ☐ No	Hospital: 1 ☐ Inpatient 2 ☐ RER/Outpatient 3 ☐ DOA Other: 4 ☐ Nursing Home 5 ☐ Residence	e 6 ☐Other (Specify)						
27. Manner of Death 1 Natural 5 ☐ Pending 2 ☐ Accident investigation	28a. Date of Injury (Month, Day, Year) 28b. Time of Injury Mork? M 28c. Injury at Work? 1 \[\text{Yes} 2 \] \[\text{No} \]							
3 ☐ Suicide 6 ☐ Could not t 4 ☐ Homicide determined		et and Number or Rural Route Number, State)						
	hysician: To the best of my knowledge, death occurred at the time, date and place, and due to the cau miner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date							

29c. License number

10063688

29d. Date signed (Month, Day, Year)

Recember

22,2009

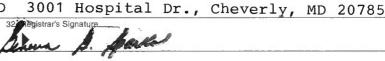
State Registrar

Griffin Davis, MD

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

29b. Signature and title of certific

31. Date filed (Month, Day.- Year)



DHMH 17 Rev 1/2001

Medical

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Month Jean Vivian Thomas ccembe Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Washington Washington County Hospital Hagerstown 7. Age (In yrs. last birthday) 5. Social Security Number 577-40-1219 8. Date of Birth (Month, Day, Year) 03/11/1931 Birthplace (State or Foreign Country) 6. Sex If Under 1 Year If Under 24 Hrs. **Funeral** Hours 1 M 2 TXT Director Usual Residence of Decedent ral", or items 23a or 28a-f show Examiner must be notified at 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits within 72 hours after death with the Maryland Director 1 Yes 2 No MD Washington Hagerstown 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 12 Walnut Street 21740 USA 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, "natural", or 1 Never Married 2 Married þ Yes 2 X No Yes, Give Baltimore, Maryland 21215-0036 1 Yes 2 No Specify: Specify: Completed 3 Widowed 4 Divorced White Year or Dates. the Medical 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) permit. Page 1 and 2 should be filed within 72 Department of Health and Mental Hygiene. Important: If item 27 is marked other than ' Elementary/Seconday (0-12) College (1-4 or 5+) Homemaker Own Home Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Jesse Albert Thomas Mary Refugio Sierra 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Saddle Ridge Rd. Myersville, MD 21773 Jesse A. Searles, son 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 🔲 Burial 2 🗍 Cremation 3 🗍 Removal from State any injury or 4 X Donation 5 ☐ Other (Specify) Uniformed Serv. Univ. 1/4/2010 Bethesda MD 21. Signature of Funeral Service Scense 22. Name and Address of Facility Rapp Funeral & Cremation Svcs. MD 20910 Gist Ave. Silver Spring, 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Immediate Cause (Final Intracranial bleeding Physician/ disease or condition Medical resulting in death) Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or linjury Examine Due to (or as a cons dence of) the burial-trans that initiated events Due to (or as a consequence of) resulting in death) Last attending physician for use as the buria Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 - Ectopic pregnancy in the past 12 months?

1 Yes 2 No
9 Unknown Month Pregnant at time of death 5 Other (specify) signed by the a d be detached f 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? by or Attending Physician: The law requires cate has been sig page 2 should b 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy perform 1 Yes 2 No within 24 hours after death.

To the Funeral Director: After this certific completed filled in by the funeral director, 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Other: 4 \(\text{Nursing Home} \) 5 \(\text{Residence} \) 6 \(\text{Other (Specify)} \) 2No မ 1 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of injury (Month, Day, Year) 27. Manner of Death 1 Natural 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred 5 Pending work? 1 ☐ Yes 2 ☐ No 2 Accident 3 Suicide Investigation 6 Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) Hospital Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier (Check

5 State

MAHMOOD 580 Northern 32. Registrar's Sig JAN 0 8 2010

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

3

only one)

Registrar

Certifying Nurse Practioner. To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated

Ave

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Hagerstown, Marylana

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	ifficate has been signed by the attending physician an	or, page 2 should be detached for use as the burial-tra		
within 24 hours after death.	To the Funeral Director: After this certi	completely filled in by the funeral directo		

		1 - State of Ma Registrar	•	epartment of F Certificate of I			iene _{=g. No} 2009	42783
Physicia	an	1. Decedent's Name (First, Middle, Last)				2. Date of Deat Month	Dav Year	3. Time of Death
/Medic	al	EVA DEAK ANDERSON		Ab City Town or	Location of Death	DECEMBE	R 17 2009	8:51 A M
Examin		4a. Facility Name (If not institution, give street and number) 6001 Muncaster Mill Road-Ca	sey Hous		ville		Montg	
Funeral			e (In yrs. last birth	Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day,	Year) 9. Bi	rthplace (State or Foreign ountry)
Director		578-58-4787	64 ^Y	rs.		Dec. 7	1945 Was	hington,D.C.
MO TO		10a. State 10b. County	10c. City, Town	or Location	,,,,,			10d. Inside City Limits
ga-fs)	Director	Md. Montgomery	Ga	ithersburg				1 ☐ Yes 2 🗹 No
23a or 28		10e. Street and Number 7304 Rosewood Manor Lane		10f. Zip Code	20882	1	og. Citizen of What C United	ountry? States
,,	by Funeral	11. Marital Status 1 Never Married 2 Married 3 Midowed 4 Divorced 12. Was Decedent 6 Armed Forces? 1 Yes 2 Marital Status 1 Yes 2 Married 1 Yes 2 Navier Status		13. Was Decedent of H If Yes, specify Cuba 1 □ Yes 2 ☑ No	ispanic Origin? (Sp n, Mexican, Puerto Specify:	pecify Yes or No- Rican, etc.)	14. Race - Am Black, Whi Specify:	
n "natur Medical	Completed	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5	(Decedent's Usual Occup (Give kind of work done of life. DO NOT use retired		ring	16b. Kind of Business	s/Industry
ygiene ygiene t, tre	Com	12 4	T)	Administrat				Company
ed oth	Be	17. Father's Name (First, Middle, Last) Frank Deak			18. Mother's Nam Julia	e (First, Middle, I Hajnac		
mark matic	٩	Frank Deak 19a. Informant's Name/Relationship (Type. Print)	19b.	Mailing Address (Street	and Number or Rui	ral Route Number	City or Town, State,	Zip Code)
Health a m 27 is her trau		Robert L. Gredone / Son	73	304 Rosewood	Manor L	ane, Gai	thersburg,	Md. 20882
tment of h tant: If Ite jury or ot		20a. Method of Disposition 1 ☐ Burial 2 ☑ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify)		Disposition (Name of y, crematory or other place oolitan Crem	12/	18/09	Alexandria	, Virginia
Depar Impor any in once.		21. Signature of Funeral Service Licensee **Burief** **W. Barles**	V	Muriel H. P. O. Bo	Barber ox 5038,	Funeral Laytonsv	Home ille, Md.	20882
		23a. Part1. Enter the disease, or complications that caused shock, or heart failure. List only one cause on each lin	the death. Do no	ot enter the mode of dyir	g, such as cardiac	or respiratory arr	est,	Approximate Interval Between Onset and Death
hysician /Medical		resulting in death)	Cancer a consequence of	f):				Onset and Death
xaminer	er	Sequentially list conditions, if any, leading to immediate Due to (or as a	a consequence of	f):				
ind transit	Examin	cause. Enter Underlying Cause (Disease or injury that initiated events c	·					
physician and the burial-transit	cal Ex	resulting in death) Last Due to (or as a	a consequence of	f):				
as the	ledical							
within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending I completely filled in by the funeral director, page 2 should be detached for use as	Physician/M	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☑No 9 ☐ Unknown 23c. If yes, outcome 1 ☐ Live birth 4 ☐ Pregnant at 9 ☐ Unknown	2 🗆 Fetal death	3 ☐ Ectopic pregnance 5 ☐ Other (specify)	y		23d. Date of do Month	elivery Day Year
igned b	by Pr	Part II. Other significant conditions contributing to death but	ut not resulting in	the underlying cause give	en in Part I.			to the cause of death?
peen s	eted						es 2 No 3 F	• • • • • • • • • • • • • • • • • • • •
ate has page 2 s	Completed					24a. Was a autops perform	y prior to ned2 death?	autopsy findings available completion of cause of
certific ector,	Be	25. Was case referred to medical examiner?		Oth	26. Place of Dear	th (Check only on	e)	II
er this	2	27. Manner of Death 28a. Date of Injur	ry 28b. Ti	ime of 28c. Injur	y at		ence 6 MOther (Sp ow injury occurred	ecify) Hospice
ath. r: Afte re fune	atior	11⊠Natura! 5 Pending (Month, Day 2 Accident investigation	<i>(, Year)</i> Inj	jury Work	? Yes 2 □No			
after de	Certification:	3 ☐ Suicide 6 ☐ Could not be determined 28e. Place of Injubuilding, etc.	iry - At home, farr c. (Specify)	m, street, factory, office		28f. Location (St City or Town	reet and Number or F n, State)	Rural Route Number,
e Funera	Medical C	29a. Certifier (Check only one) 1 Certifying Physician: To the best of and manner stars.	examination and					
withir To th comp	Me	29b. Signature and title of certifier J. KO W OLPCHO W , V.	ns	29c. Licens	e number	2	9d. Date signed (Mor	nth, Day, Year) 17, 2009
0	ļ	30. Name and address of person who completed cause of do Jocelyne Kouatchou, M.D.		Type, Print) uncaster Mi	11 Rd., F	Rockville	e, Md. 20	855
Stat		31. Date filed (Month, Day, Year) 32. Registra	ar's Signature					
Registra	ar	DEC 18 2009 Since	w B.	parker				

DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death **Physician** December 2009 Anthony W. Bernardi 26. /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death Examiner Harford Memorial Hospital Havre de Grace Harford If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) 5. Social Security Number 6. Sex 7. Age (In vrs. last birthday) **Funeral** Days Months Hours Min. 1 M 2 F Director <u> 215-56-1885</u> 60 09/10/1949 Maryland Usual Residence of Decedent permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hyglene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Evantina must be notified at once. 10d. Inside City Limits 10c. City, Town or Location 10a. State 1 Kes 2 No Funeral Director MD Havre de Grace Harword 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number 823 Erie Street 21078 u.s.A. 12. Was Decedent Ever in U.S. Armed Forces? 1 1 Yes 2 □ No If Yes, Give Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 X Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 If Yes, Give Year or Dates: 1970–72 1 ☐ Yes 2 No Specify: Specify: Completed by 3 Widowed 4 Divorced White 16b. Kind of Business/Industry 16a, Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) College (1-4or 5+) Elementary/Secondary (0-12) Landscaping Groundskeeper 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Joseph T. Bernardi Alice F. Stout ပ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 823 Erie Street, Havre de Grace, MD 21078 Ronnie Bernardi (Brother) 20c. Location - City or Town, State 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Mt. Erin Cemetery 12/30/2009 Havre de Grace, MD 22. Name and Address of Facility Zellman Funeral Home, P.A. Signature of Funeral Service Licenses 123 S. Washington Street, Havre de Grace, MD Approximate Interval Between Onset and Death art 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List on yone ausum each line. Immediate Cause (Final **Physician** disease or condition resulting in death) /Medical Due to (or a / a consequence of): Examiner Sequentially list conditions, Examiner Directo (or as a consequence of) if any, leading to immedia cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last The law requires that the death certificate be executed sician and burial-trans Due to (or as a consequence of) attending physician for use as the buria Physician/Medical 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Fctopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 4 Pregnant at time of death 5 Other (specify) signed by the a 9 I Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. \$ 4 Unknown 1 ☐ Yes 2 ☐ No 3 ☐ Probably certificate has been s rector, page 2 should Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy 1 ☐ Yes 2 ☐ No 1 ☐ Yes funeral director, 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA Certification: To this Date of Injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural 2 Accident 5 Pending investigation 1 □Yes 2 □ No 6 Could not be determined 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 🗌 Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide

Division of Vital Records, P.O. Box 68760, Hospital or Attending Physician: ours after death.

neral Director: A
filled in by the fu 24 hours a

completely within 2 To the

State

Medical

29a. Certifier

(Check only

29b. Signature and title of cert

31. Date filed (Month, Day, Year)
DEC 2 8 2009

and address of person who completed cause of death (Item 23a) (Type, Print)

2027

32. Registrar's Signature

Ropp

Highway

Pulasti

Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29c. License number

29d. Date signed (Month, Day, Year)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 2009 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ 2009 December A M Nancy Irene Bland 4:52 Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death 59 Cutter Crossing Chestertown Kent 5. Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** 1 □ M 2 🗓 F Months Days Hours (Month, Day, Year) 11/4/1929 Director 220-26-1234 80 MD Usual Residence of Decedent permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at 10a. State 10b. County 10c. City. Town or Location 10d. Inside City Limits Director 1 Yes 2 No Kent Chestertown 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 59 Cutter Crossing 21620 USA Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 11. Marital Status 14. Race - American Indian, Armed Forces?
1 ☐ Yes 2 🔀 No Black, White, etc. ò 1 Never Married 2 X Married Maryland 21215-0036 Specify: White If Yes, Give 1 ☐ Yes 2 X No Specify 3 - Widowed 4 - Divorced Completed Year or Dates 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) 12 Private Duty **Healthcare** Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) မ George W. Townsend Addie Frances Fithian 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Nancy Stoops Blizzard/Daughter 1 Rosedale Dr. Stafford, VA 22556 Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State 4 Donation 5 Other (Specify) Chester Cemetery 12/26/09 Chestertown, MD Signature of Funeral Service Licensee 22. Name and Address of Facility
Fellows, Helfenbein & Newnam Funeral Home
130 Speer Rd. Chestertown, MD 21620 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Immediate Cause (Final Onset and Death Physician/ ADVANCED DEMENTIA disease or condition resulting in death) Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examine Due to (or as a consequence of) that the death certificate be executed Cause (Disease or linjury that initiated events resulting in death) Last Due to (or as a consequence of): physician a the burial-Physician/Medical 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy
5 ☐ Other (specify) in the past 12 months?

1 Yes 2 No
9 Unknown Month Dav Year P.0. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ POLYMYALGIA RHEUMATICA Records, 1 ☐ Yes 2 👿 No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy perform 2 No 1 Yes 2 X No To the Hospital or Attending Physician: within 24 hours after death.

To the Funeral Director. After this certifical completed filled in by the funeral director, to 25. Was case referred to medical Be 26. Place of Death (Check only one) 1 ☐ Yes 2 X No မှ 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 4 Nursing Home 5 Residence 6 Other (Specify) 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred 1 Natural 5 Pending 1 ☐ Yes 2 ☐ No 2 Accident
3 Suicide
4 Homicide Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier (Check Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29d. Date signed (Month, Day, Year) D0041587 12-22-09 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

DHMH 17 Rev 7/2009

State Registrar

Box 68760

Division of Vital

NOBLE

31. Date filed (Month, Day, Year)

MID

32. Registrar's Signature

127 SPEER RD CHESTERTOWN, MD 21620

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Namair Borum		State of Maryland / Departing For State Certification Certificat	ificate of		ıtai riyy		. No. 2009	42786
Physicia Medical Examir	n/	1. Decedent's Name (First, Middle,Last) Kamarr Earl Borum				Date of Death Month I December 2	Day Year	3. Time of Death 1141 hrs
Wiculcal Examin		4a. Facility Name (if not institution, give street and number)		4b. City, Town, or Location		December 2	4c. County of Death	
بيبال		Fort Washington Medical Center 5 Social Security Number	at hidhday)	Fort Washington	er 24Hrs. 8	Date of Righ	Prince George (MM/DD/YYYY) 9. Birl	
Funeral Director		577-51-0011 1XM 2F	Yrs	Months Days Hours			18, 200 9 Co	n DC
any	ŀ	,	own or Locat			<u></u>		10d Inside City Limits
land f show	ō		hingto					1 X Yes 2 No
h the Mary 3a or 28a- totified at a	1 Director	10e. Street and Number 1464 Bruce Place, S. E.		10f. Zip Code 20020			U. S. A.	
Baltimore, MD 21215-0036 permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show injury or other traumatic event, the Medical Examiner must be notified at once.	/ Funeral	11. Marital Status 1 X Never Married 2 Married 3 Widowed 4 Divorced If Yes, Give Year	If Y	as Decedent of Hispanic Ori 'es, specify Cuban, Mexicar Yes 2 No specify	n, Puerto Ric		White, etc.	can Indian, Black,
ours af	ğ 5	(nt's Usual Occupation (Give			16b. Kind of Business/I	industry
36 iin 72 h iin 72 h iin 72 h	Completed by	Elementary/Secondary (0-12) College (1-4 or 5+)	none				none	
5-00; ed with lygiene other t	틩	17. Father's Name (First, Middle, Last)		18.Mothe	r's Name (Fi	rst, Middle, Ma	aiden Surname)	
1215 d be fill ental H arked	8	Earl Borum	Table Marie	Dan g Address (Street and Nur	ika Mo		as City or Town State	Zin Codo)
AD 2 2 should and M 27 is m matic	ပ္	19a. Informant's Name/Relationship (Type, Print) Michelle McCrae (Grandmother)		4 Bruce Place	s, S.E	. Was	hington, D	C 20020
re, N : 1 and : f Health f item			ace of Dispos ematory or ot	sition (Name of cemetery, her place)		- 1	20c. Location - City or	
Pages ment of		4 Donation 5 Other Specify:		Cemetery	01/05	/2010	Washingt	on, DC
Balt permit Depart Impor	ļ	2) Si prible of Funers Service Licensee	/ W.	Name and Address of Facilit H. B a con Fu 3447 <u>14th Str</u>	neral	Home,	Inc. Mashington	DC 20010
Physician	9	2 a 1. Enter the disease, or complications that caused the death. If fillure, last only one cause on each line.	Do not enter t	he mode of dying, such as	cardiac or re	spiratory arres	st, shock, or heart	Approximate Interval Between Onset and
Medical Examiner	1	Immediate Cause (Final disease a. <u>Sudden unexpla</u>		leath in infa	ncy			Death
,		or condition resulting in death) Due to (or as a consequence of): Sequentially list conditions, b.						
	Ē	if any, leading to immediate cause Finer Underlying Cause						
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'60, ate be	Med	IF FEMALE: 23c. If yes, outcome of pregna	a-f,pe	ermE, g900 2/	3/10 1	rr	23d. Date of deliver	,
Division of Vital Records, P.O. Box 68760, To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial - transi	Physician/Medical Examiner	23b. Was decedent pregnant in the past 12 months? 1	46	etal death 3 Ectop	ic pregnancy		Month [Day Year
O. E at the of the etached		Part II. Other significant conditions contributing to death but not res	sulting in the (underlying cause given in P	art I.		acco use contribute to	
S, P puires th	ed by					1 Yes		utopsy findings available
cords law requi	ompleted					autops)	y prior to oned? death?	completion of cause of
tal Rec	O	25. Was case referred to medical		26.Place of Death	(Check only	1 Yes 2	No 1 ✓ Ye	es 2 No
Vital hysician: this certifi	To Be	examiner? 1 Yes 2 No Hospital: 1 Inpatient 2 E			Nursing H		tesidence 6 Othe	r:
Division of 'pital or Attending Phours after death. Peral Director: After filled in by the funeral		27. Manner of Death 1 Natural 5 Pending 2 Accident Investigation Fd 12/26/09	28b. Time of I	1 Yes X	1 4 4 4	d. Describe ho nknown	while bed	sharing
DIVIS Hospital or At 24 hours after d Funeral Directed filled in by	Certification:	3 Suicide 6 X Could not be determined (Specify) a reside		et, factory, office building, e		f. Location (Stor Town, Star xon Hi	(412 Wins)	Iral Route Number, City
D To the Hospital within 24 hours To the Funeral completely filled	Medical C	29a. Certifier (Check only one) 2 Medical Examiner: On the basis of examination and and manner stated.	e, death occur d/or investiga	rred at the time, date and pl tion, in my opinion, death o	lace, and du	e to the cause e time, date a	(s) and manner as stat nd place, and due to th	ed. ne cause(s)
	ž	29b. Signature and title of certifier		29c. License number	r		29d. Date signed (Mo December 27, 2)	
<u> </u>		30. Name and address of person who completed cause of death (Item 2	23a)					-
8				Street, Baltimore, MI	21201			
	ate	31 Date filed (Month, Day, Year) 32. Registrar's Signature	ake					
DHMH 17 Rev 1/20		0 1 2010	ORIGINA	AL.		-		
OCME 2006								

10:40 P.M

Baltimore, Maryland 21215-0036

Division of Vital Records, P.O. Box 68760

		Bethesda Health	& Rehabili	tatio	n Cen	ter	Che	vy Cl	hase			Mont	gomery
Funeral Director		5. Social Security Number 6. S 577-56-7296	ex 7.Ag	e (In yrs. las 66	st <i>birthday)</i> Yrs.	If Under Months	1 Year Days	If Under Hours		B. Date of Birt (Month, Dat arch I	th y Year)	9, Bi 943 Was	rthplace (State or Foreign ountry) hington, D.C.
d t ow	L	Usual Residence of Decedent 10a. State 10b. County		100 Ciby	Town or Lo	nation							1404
farylan 3a-f sh lified a	Director	District of Colu	mbia	Toc. City,		ingto	n						10d. Inside City Limits 1 X Yes 2 No
the M		10e. Street and Number				10f. Zip	Code				10g. Cit	izen of What C	ountry?
h with	Funeral	1222 "T" Street,	N. W.; AI	ot. 10)2	20	009				Uni	ted Sta	ites
r deat r iten iner r		11. Marital Status 1 ☐ Never Married 2 ☐ Married	12. Was Decedent I Armed Forces?			Was Decede If Yes, speci	ent of His fy Cuban	spanic Orio n, Mexican	gin? (Specif n, Puerto Ric	y Yes or No- can, etc.)		14. Race - Am Black, Whi	
permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Heath and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.	ted by	3 Widowed 4 X Divorced	1 ☐ Yes 2 🛣 If Yes, Give Year or Dates.	No		1 ☐ Yes 2	X No	Specify:				Specify: B	1ack
72 hou n "nat ledica	Completed	15. Decedent's E (Specify only highest gr			(Give	dent's Usual kind of work	done du	tion uring most	t of working		16b. K	ind of Business	s Industry
within giene. er thau	Co	Elementary/Seconday (0-12) 12th grade	College (1-4 or 5	5+)		Drive Drive		elive	ery Ma	ın	Bro	oklyn H	lorist
filed tal Hyg d oth		17. Father's Name (First, Middle, Last)								irst, Middle,			
uld be I Ment narke	욘		ailey, Jr.					Pau	ıline	Patri	icia	Cooper	• •
2 shouth and the and traum		19a. Informant's Name/Relationship (7)		Ciata		-						Town, State, Z	
item 2		Bernadette Baile 20a. Method of Disposition	y carter (20b. Pla	ace of Dispo	sition (Name	e of					ocation - City o	
Page nent or ant: If ant: If ant: If		1 ☐ Burial 2 X Cremation 3 ☐ 4 ☐ Donation 5 ☐ Other <i>(Şpeci</i>		ce	metery, crei	matory or oth ke Cr	her place	orv.	Dec.20 Inc.	5,2009			Maryland
permit. Departr Imports any inju		27. Signature of Funeral Service Licens		1	-/-					Hort			Morticians,
20 E # 8		Jandalel	2 9 7	tul								Washing	ton,D.C.2001
		23a. Part 1. Enter the disease, or com shock, or heart failure. List only o	plications that cause ne cause on each line	the death.	Do not ent	er the mode	of dying	, such as	cardiac or re	espiratory arr	est,		Approximate Interval Between
Physician/ Medical		Immediate Cause (Final disease or condition resulting in death)	a. Chronic			ve Pu	1mon	ary 1	Disea	se			Onset and Death
Examiner		Due to (or as a consequence of):											
n #	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying	Due to (or as a	a conseque	ence of):							8	
executed an and rial-transit	Exan	Cause (Disease or iinjury that initiated events resulting in death) Last Due to (or as a consequence of):											
		resulting in deathy 2000	L a	a osmooquo									
ifficate ng phys as the	Medi	IF FEMALE:	d	•									
h cert tendin r use	an/	23b. Was decedent pregnant in the past 12 months?	23c. If yes, outcome 1 Live Birth	of pregnand	cy death 3 [☐ Ectopic pr	regnancy	,			8	23d. Date of de	
e death the atte hed for	by Physician/Medical	1 Yes 2 No	4 ☐ Pregnant a 9 ☐ Unknown			Other (spe						Month	Day Year
hat the ed by i	y Ph	Part II. Other significant conditions c	ontributing to death b	ut not resul	Iting in the u	ınderlying ca	ause give	en in Part I		23e. Did to	bacco u	se contribute t	o the cause of death?
uires that n signed b	70 I									1 🗆 🗅	Yes 2	X No 3 □ F	Probably 4 🗆 Unknown
w require is been si 2 should	Complete									24a. Was a			utopsy findings available
The la ate ha page 2	<u>ا</u> ق									autop perfoi 1 Yes	rmed? 2 🔼 No	death?	completion of cause of
sician: The la certificate ha irector, page?	B B	25. Was case referred to medical examiner?	Hospital:				_		h (Check or	nly one)			
Physic this cral dir	일	1 ☐ Yes 2 X No 27. Manner of Death			R/Outpatier	nt 3 🗆 DO	C. Injury	4 🕰 Nu				Other (Spe	cify)
nding ath. :: After e fune	Certificate:	1 X Natural 5 Pending 2 Accident Investigation	(Month, Day		injury	M Z	work?			l. Describe h	ow injury	occurrea	
er dea ector by th	ertifi 	3 ☐ Suicide 6 ☐ Could not b 4 ☐ Homicide determined		ry - At hom	ne, farm, str	eet, factory,			_			d Number or Ru	ural Route Number,
oital or urs aft ral Di		<u></u>								City or Tow			
To the Hospital or Attending Physician: The law requir within 24 hours after death. To the Funeral Director: After this certificate has been completed filled in by the funeral director, page 2 should	Medical	(Check 2 L Medical Exami	sician: To the best of ner: On the basis of ex se Practioner: To the	camination a	and/or inves	tigation, in m	y opinion	, death oc	curred at the	time, date ar	nd place,	and due to the	cause(s) and manner stated.
To the To the company	— r	29b. Signature and title of certifier					License r					e signed (Mont	
		•	m/2	~ 1	mo		906	571	24		Dec	ember 🗡	4, 2009
R/		30. Name and address of person who or Truong Bao, M.D.					uite	206	;Rock	ville,	Mary	land 2	0850
Stat	e	31. Date filed (Month, Day, Year)	32. Registra			-,-			-				
Registra	ır	DEC 2 8 2009	knows &	. 196	West								

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

			for State of N Registrar	laryland / Dep <i>Ce</i>	oartment of F e <i>rtificate of l</i>			ene 2009	3 42788		
1	Dhysisi		Decedent's Name (First, Middle, Last)				Date of Death Month		3. Time of Death		
	Physici /Medio		Gary D. Bailey				12-12-20	09	4:34 pm M		
-	Examin	er	4a. Facility Name (If not institution, give street and numbe		4c. County of Dea	th					
and of	Funeval		Union Hospital 5. Social Security Number 6. Sex 7. A	Age (In vrs. last hirthday	-	Maryland If Under 24 Hrs.	8 Date of Birth		thnlace (State or Foreign		
	Funeral Director		221-34-8550 Usual Residence of Decedent	Age (In yrs. last birthda) 9 Yrs.	Months Days	Hours Min.	8. Date of Birth (Month, Day, 12–26–19	Year) C 49 De	thplace (State or Foreign ountry) elaware		
	yland how		10a, State 10b. County	10c. City, Town or I	Location				10d. Inside City Limits		
	Sa-fs	Director	DE New Castle	Newark					1 □ Yes X□ No		
	iff the or 28	Dire	10e. Street and Number		10f. Zip Code		10	g. Citizen of What C	ountry?		
	s 23a	eral	50 N. Skyward Drive		1991:	-		USA			
Maryland 21215-0036	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hyglene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show amy injury or other traumatic event, in M. dical Evri-ding must be nuitified at once.	by Funeral	11. Marital Status 1 □ Never Married 2 □ Married 3 □ Widowed 4 ☑ Divorcèd 12. Was Deceden Armed Forces 1 ☒ Yes 2 □ If Yes, Give Year or Dates] No	3. Was Decedent of H. If Yes, specify Cuba 1 □ Yes 2 ☑ No	ispanic Origin? (Spanic Origin, Mexican, Puerto Specify:	ecify Yes or No- Rican, etc.)	14. Race - Am Black, Whit			
5-0	72 ho	Completed	15. Decedent's Education (Specify only highest grade completed)	16a. Dec	cedent's Usual Occup	ation during most of worki	na 1	6b. Kind of Business	/Industry		
121	vithin sne. than "	mp	Elementary/Secondary (0-12) College (1-4or	5+) life.	ve kind of work done of DO NOT use retired))	g	Health/Si	tting Service		
d 2	filed v Hygie other 1	ပိ	12 2+ 17. Father's Name (First, Middle, Last)		Caregiver	18. Mother's Name					
au	ld be lental ked c	To Be	Elbert C. Bailey, Jr.				1 Burton	· ·			
ary	should and Men s marke	-	19a. Informant's Name/Relationship (Type. Print)	19b. Mai	iling Address (Street a	and Number or Rura	al Route Number,	City or Town, State,	Zip Code)		
	and 2 ealth a n 27 is		Craig Bailey (Brother)	25 L	ocust Ave	. Annapol	is, Md.	21401			
Baltimore,	Pages 1, nent of He ant: If iten ury or oth		20a. Method of Disposition 1 ☐ Burial 2 □ Cremation 3 □ Removal from State	20b. Place of Disp cemetery, cri	position (Name of ematory or other plac	e) [Date 2	Oc. Location - City or	Town, State		
<u>=</u>	t. Pag tmen tant: ijury	1	4 Donation 5 Other (Specify)	Laurel H	Iill Cem.		16, 200	9 Laurel			
Ba	permit. Departr Importa any inju		21. Signature of Funeral Service Licensee	. —	22. Name and Addres		oroon F		t Street De. 19956		
		10	23a, Part 1, Enter the disease, or complications that cause	CONTON -					Approximate		
	Physician	ř	23a. Part 1. Enter the disease, or complications that cause shock, or heart value. List only one cause on each immediate Cause (Final						Interval Between Onset and Death		
Sec. of	/Medical		Immediate Cause (Final disease or condition resulting in death) a. Multissem or fan tachre wiff cardi w arrest Due to (or as a consequence of):								
	Examiner		Seo								
	pe #i	iner	Sequentially list conditions, if any, leading to mineurate cause. Enter Underlying Cause (Disease or injury that initiated events	э а сонъециеное об).							
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687	tificate be executed g physician and as the burial-transit	edical	d								
	The law requires that the death certific atte has been signed by the attending page 2 should be detached for use as to	Physician/M		2 ☐ Fetal death 3 at time of death 5	B	1		23d. Date of de Month	olivery Day Year		
ν, σ.	s that gned t		Part II. Other significant conditions contributing to death	but not resulting in the	underlying cause give	en in Part I.	23e. Did toba	acco use contribute t	o the cause of death?		
ğ	en sig	edk	Bilateral pulmonary embili	, cerebro	vesuler a	walnt -	1 ☐ Yes	3 2 □ No 3 □ F	robably Unknown		
Records,	ician: The law re certificate has be ector, page 2 sho	Completed by	har kasing	raney fail	me, profo-	nel	24a. Was an autopsy perform	prior to ed2 death?	utopsy findings available completion of cause of		
Vital	sian: ertifica ctor, p	BeC	25. Was case referred to medical examiner?			26. Place of Death		(s 2 No		
> -	hysic this ce al dire	၉	1 Yes 2 No Hospital: 1 Inpat	tient 2 ER/Outpatie	ent 3 ☐ DOA Othe	er: 4 🗆 Nursing Hor	me 5 🗆 Resider	nce 6 □ Other (Spe	ecify)		
Ĕ	ling F	ioi:	27. Manner of Death 1 Natural 5 □ Pending (Month, D	jury 28b. Time Pay, Year) Injury	Work	.?	28d. Describe hov	v injury occurred			
DIVISION	death ctor: y the	licat	2 ☐ Accident investigation 3 ☐ Suicide 6 ☐ Could not be 28e Place of Ir	njury - At home, farm, s		Yes 2□No	28f Location (Str	eet and Number or F	lumi Pouto Alumbos		
2	al or / after Dire d in b	Certification:	4 ☐ Homicide determined building, e	etc. (Specify)	,,,		City or Town,	State)	urai rioute rvuinbei,		
	To the Hospital or Attending Physician: within 24 hours after death. To the Funeral Director: After this certification of the Funeral director, the funeral director, it is a completely filled in by the funeral director, it is a completely filled in by the funeral director, it is a completely filled in by the funeral director, it is a completely filled in by the funeral director, it is a completely filled in by the funeral director, it is a completely filled in by the funeral director, it is a completely filled in by the funeral director.	edical (29a. Certifier (Check only one) Certifying Physician: To the bess and manners and manners	of examination and/or i	ath occurred at the tin investigation, in my op	ne, date and place, pinion, death occurr	and due to the ca ed at the time, da	use(s) and manner a te and place, and du	as stated. e to the cause(s)		
	Vithir Comp	Me	29b. Signature and title of certifier		29c. License	number	29	d. Date signed (Mon	th, Day, Year)		
	MULL		Kein lein		1069	1048	ĺ	2/14/20	05		
	450		30. Name and address of person who completed cause of	death (Item 23a) (Type	Print)		10 2192	Ī			
	Sta		31. Date filed (Month Day Year) 8 2000 32. Regis	Sow Str. trar's Signature	hadel						
	Registra	ar	0 2003 Acr	p. H	gavi						

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ December Day 8. 12:04 am Patricia Bailer 2009 Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City. Town, or Location of Death 4c. County of Death Montgomery General Hospital Olneu Montgomery 5. Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** Months Days Hours Min 0277371929 Washington, DC Director 578-36-8269 80 Usual Residence of Decedent or 28a-f show notified at 1 and 2 should be filed within 72 hours after death with the Manyland of Health and Mental Hygiene.

The stream of the stream of the stream of the stream stream of the st 10a, State 10c. City, Town or Location Director 10d. Inside City Limits Maryland Silver Spring 1 X Yes 2 No Montgomery 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? ems 23a or Funeral 14801 Maydale Court 20905 U.S.A. 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 🛛 No 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Black, White, etc. þ 1 Never Married 2 Married Maryland 21215-0036 If Yes, Give Year or Dates 1 ☐ Yes 2 X No Specify. 3 X Widowed 4 Divorced Specify. White Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) Office Manager Plastering Company Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) ၉ Stanley Romanek Agnes Raffo permit. Page 1 and 2 should be Department of Health and Men Important: If item 27 is marke any injury or other traumatic 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Mark Bailer - Son 23294 Esperanza Drive, Lexington Park, MD 20653 3altimore, 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 1 Burial 2 X Cremation 3 Removal from State 4 ☐ Donation 5 ☐ Other (Specify) <u>Lincoln Crematori 12/24/2009 Brentwood, Maryland</u> Signature of Funeral Service I 22. Name and Address of Facility Hines-Rinaldi Funeral Home, Inc. 11800 New Hampshire Ave., Silver Spring. MD 20904 23a. Fart 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Pulmonary Physician disease or condition resulting in death)) Medical Due to (or as a consequence of) Examiner Sequentially list conditions Examiner if any, leading to immediate

Cause (Disease or iinjury Due to (or as a consequence of) been signed by the attending physician and should be detached for use as the burial-transit To the Hospital or Attending Physician: The law requires that the death certificate be executed that initiated events resulting in death) Last Due to (or as a consequence of) Completed by Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23b. Was decedent pregnant 23d. Date of delivery in the past 12 months?
1 Yes 2 No Month Day Year 1 ☐ Yes 2 ☐ 9 ☐ Unknown Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Acute renal failure 1 Yes 2 No 3 Probably 4 Onknown 24b. Were autopsy findings available prior to completion of cause of death? To the rusping within 24 hours after death.

If the Funeral Director: After this certificate has silled in by the funeral director, page 2. performed? 25. Was case referred to medical l e 26. Place of Death (Check only one) examiner' 2 110 1 🗌 Yes Other: ြု 1 Propatient 2 ER/Outpatient 3 DOA 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 27. Manner of Death Certificate: 28a. Date of injury (Month, Day, Year) 28c. Injury at work? 28b. Time of 28d. Describe how injury occurred Natural 5 Pending 1 ☐ Yes 2 ☐ No 2 Accident Investigation Suicide 6 Could not be 4 Homicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, determined City or Town, State) Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Registrar DHMH 17 Rev 7/2009

State

29b. Signature and title of certifier

wanto

31. Date filed (Month, Day, Year)

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Mont

omer

29d. Date signed (*Month*, *Day*, *Year*)

Hospital, olnow

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month 5 Virginia Bowmann .vda Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death • Examiner HICANICA PENINSULA REGIONAL MEDICAL 50/135414 If Under 1 Year If Under 24 Hrs 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** 1 □ M 2 🏿 F Months Days Hours Min. 5/10/1916 **Director** 214-30-7700 93 Maryland Usual Residence of Decedent 28a-f show 27 is marked other than "natural", or items 23a or 28a-f sho traumatic event, the Medical Examiner must be notified at 10b. County 10c. City, Town or Location 10d. Inside City Limits Director 1 Tes 2 X No Salisbury Maryland Wicomico 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral USA 21804 130 Francis Drive 72 hours after death 12. Was Decedent Ever in U.S. Armed Forces? 1 — Yes 2 🙀 No 13. Was Decedent of Hispanic Origin? (Specify Yes or No-11. Marital Status 14. Race - American Indian If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Black, White, etc ğ 1 Never Married 2 Married If Yes, Give 1 Yes 2 No Specify: Specify: White 3 Midowed 4 Divorced Completed Year or Dates 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) and Mental Hygiene. Elementary/Seconday (0-12) College (1-4 or 5+) Hardware Manager æ permit. Page 1 and 2 should be filed i Department of Health and Mental Hyy Important: If item 27 is marked oth any injury or other traumatic event, 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) မ Edith Booze Ivy Jones 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 130 E. Main St., Salisbury, Maryland 21801 Don Richardson/personal Rep. 20a. Method of Disposition 20b. Place of Disposition (Name of Date 20c. Location - City or Town, State 1 🛮 Burial 2 🗆 Cremation 3 🗆 Removal from State Dorchester Memorial 4 Donation 5 Other (Specify) Cambridge, Maryland <u>Park</u> Signature 22. Name and Address of Facility Holloway Funeral Home Maryland 21804 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between Onset and Death shock, or heart failure. List only one cause on each line Immediate Cause (Final ASC Physician/ disease or condition resulting in death) Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Examiner Due to (or as a consequence of) physician and the burial-transit death certificate be executed that initiated events resulting in death) Last Due to (or as a consequence of) nding physician Physician/Medical use as IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? 1 Yes 2 No Month Day Year Pregnant at time of death 5 Other (specify) isigned by the a Id be detached f 9 Unknown g Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? by 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an Hospital or Attending Physician: The law cate has I page 2 s autopsy 1 ☐ Yes 2 ☐ No 25. Was case referred to medical examiner? 1 Yes 2 No funeral director, Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Inpatient 2 ER/Outpatient 3 DOA 2 this (27. Manner of Death 28a. Date of injury (Month, Day, Year) Certificate: 28b. Time of 28c. Injury at 28d. Describe how injury occurred injury work? 1 Yes 2 No Natural 5 Pending To the Hospital or Attendia within 24 hours after death. • To the Funeral Director: At completed filled in by the fu death. Accident Investigation Accident Suicide Homicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f, Location (Street and Number or Rural Route Number, determined Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Baltimore, Maryland 21215-0036

Box 68760

P.O.

Records,

Division of Vital

State Registrar 29b. Signature and title of certifier

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

DHMH 17 Rev 7/2009

106 Milkord

29d. Date signed (Month, Day, Year)

ST, # 504B, Salisbury, MD21804

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

	-	For State Registrar	State of	Marylan		rtment of F tificate of t			jiene _{eg. No} 2 () (9 42791	
Physicia /Medica		1. Decedent's Name (First, Midd Robert Le	lle, Last) ee Banks					2. Date of Deat Month Decembe	Day	Year 3. Time of Death p	
Examine		4a. Facility Name (If not institution ATLANTIC GENERA		•		4b. City, Town, or BERLIN	Location of Death		4c. County of Death WORCESTER		
Funeral Director		5. Social Security Number 218–20–6606	6. Sex 7 1 X M 2 □ F	. Age (In yrs. I	last birthday) Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth Month, Day 12/25/	1952	9. Birthplace (State or Foreign Country) Maryland	
show	ō	Usual Residence of Decedent 10a. State 10b. County Maryland Word	cester		y, Town or Loc Newark	ation				10d. Inside City Limits 1 □Yes 2 ☑ No	
with the N	Funeral Director	10e. Street and Number 8615 Tindle		<u></u>	- CWALIE	10f. Zip Code 2184	11	1	0g. Citizen of W		
al",o	ò	11. Marital Status 1 ★ Vever Married 2 Mar 3 Widowed 4 Divorced	12. Was Deced Armed Force 1	es? [X No	1	Vas Decedent of H Yes, specify Cuba □Yes 2 X No	ispanic Origin? (Sp n, Mexican, Puerto Specify:	o Rican, etc.)	14. Race Black Specify:	- American Indian, , White, etc. white	
d within 72 h giene. er than "nati	Completed	15. Decede (Specify only higher Elementary/Secondary (0-12) n/a	nt's Education est grade completed) College (1-4	lor 5+)	(Give k life. D	ent's Usual Occup aind of work done o O NOT use retired Lly & phy	during most of worl)	king	pped 1	n/a	
uld be file Mental Hy irked oth itic event	To Be (17. Father's Name (First, Middle, Curtis Samuel						e (First, Middle, I Helen Wo		9)	
and 2 shot and 2 stores at the and 1 stores and 1 stores are trauma		19a. Informant's Name/Relation: Noreen Short/o				g Address <i>(Street a</i> 5 Tindley				State, Zip Code)	
Pages 1 and of He nt: If item into or oth		20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 4 ☐ Donation 5 ☐ Other (5		ate C	emetery, crem	ition (Name of atory or other plac Cemetery	e) ;	Date 23/09		City or Town, State	
permit. Departn Importa any inju		21. Signature of Funeral Service	Licensee		- 22 Ho	Name and Address DI TOWAY E	uneral H	ome Prof	essiona ry, MD	l Association 21804	
Physician		23a Fart1. Enter the disease, o shock, or heart failure. Lis Immediate Cause (Final disease or condition	r complication man cal t only one can se on vac	used the death ch line.	h. Do not ente	er the mode of dyin		or respiratory arr	est,	Approximate Interval Between Onset and Death	
/Medical Examiner		resulting in death)	Due to (o	r as a conse	uence of)	m. ef	21'mno	id col	m -		
icate be executed physician and sthe burial-transit	edical Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): c. Due to (or as a consequence of): Due to (or as a consequence of):									
# D = 1	Pnysician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown		th 2 ☐ Fetal int at time of d	I death 3 🗌	Ectopic pregnancy Other (specify)	/		23d. Date Mon	of delivery th Day Year	
en signed b	2	Part II. Other significant conditi	ions contributing to dea	th but not resu	ulting in the un	derlying cause give	en in Part I.		bacco use contri es 2 ☐ No	bute to the cause of death? 3 ☐ Probably 4 Ûnknown	
The law recate has be page 2 sho	Completed							24a. Was a autops perfori	sy pr med? de	/ere autopsy findings available rior to completion of cause of eath? □Yes 2 ★ No	
sician: certifii rector,	g R	25. Was case referred to medica examiner? 1 ☐ Yes 2 XNo	Hoonitals fi .			Othe	ar.	th (Check only on			
nding Physith.	ation: 10	27. Manner of Death ĵXNatural 5 □ Pendii	28a. Date of		ER/Outpatient 28b. Time of Injury	28c. Injury	4 □ Nursing H	ome 5 Reside			
s after dez	Certification:	3 Suicide 6 Could 4 Homicide deterr	ningd 28e. Place 0	f Injury - At ho g, etc. <i>(Specif</i>)	ome, farm, stre	et, factory, office		28f. Location (S. City or Town		r or Rural Route Number,	
he Hospii in 24 hour he Funera pletely filla	Medical	29a. Certifier 1 Certifyi (Check only one) Certifyi	ng Physician: To the b I Examiner: On the bas and manne	sis of examina	wledge, death tion and/or inv	occurred at the tirestigation, in my o	ne, date and place pinion, death occu	, and due to the or rred at the time, o	cause(s) and ma late and place, a	nner as stated. nd due to the cause(s)	
Within Com	Σ	29b. Signature and title of certific	A . D			29c. Licenson	C.112 0	/	12/18/	(Month, Day, Year)	
Ner		AKIF Zeerhoun	who completed cause 9733	of death (Item	n 23a) (Type, F	1 Drive	Berli	in Ac	ud 911	3/)	
State Registra		31. Date filed (Month, Day, Year,	2009 32 Re	gistrar's Signat	ture spa	Ne					

DOB: 12125 | 52 DOD: 12 18 log TOD: 13:3

Baltimore, Maryland 21215-0036

218-20-6606 P.O. Box 68760,

Division of Vital Records,

Banks, Robert L. 55#

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 3. Time of Death 2. Date of Death Physician/ Month Juanita Baker 2009 Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death Examiner 4c. County of Death HICOMICO Birthplace (State or Foreign Country) 8. Date of Birth **Funeral** If Unde Days (Month, Day, Year) 07/19/1924 1 □ M 2 🛛 F Hours 407-28-5449 85 **Director** Kentucky Usual Residence of Decedent Item 27 is marked other than "natural", or items 23a or 28a-f shov other traumatic event, the Medical Examiner must be notified at 10a. State 10c. City, Town or Location 10d. Inside City Limits Director Marvland Wicomico Salisbury 1 X Yes 2 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 21804 1310A Middleneck Drive USA death v 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian Black, White, etc. þ 1 Never Married 2 Married 1 ☐ Yes 2 X No Baltimore, Maryland 21215-0036 within 72 hours after 1 ☐ Yes 2 😾 No Specify: white 3 ☑ Widowed 4 ☐ Divorced Specify: Completed Year or Dates Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Page 1 and 2 should be filed within 72 nent of Health and Mental Hygiene. ant: If Item 27 is marked other than ' Elementary/Seconday (0-12) College (1-4 or 5+) homemaker domestic Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Floyd Miller Ollie Derossett 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 5918 Kilbirnie Dr., Salisbury, MD 21804 Gary Baker/son 20a. Method of Disposition 20b. Place of Disposition (Name of Date permit. Page 1 a Department of H Important: If ite any Injury or ot Wicomico Memorial 1
Burial 2 Cremation 3 Removal from State 4 Donation 5 X Other (Spenit) ombment 12/23/09 Salisbury, MD 21. Signature of Funeral Service Lice Professional Association 501 Snow Hill Rd., Salisbury, MD 21804 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Ph sician/ disease or condition resulting in death) Medical Due to (or as a consequence of) Examiner Sequentially list conditions if any, leading to immediate cause. Enter Underlying Due to (or as a consequence of) Exami The law requires that the death certificate be executed Cause (Disease or linjury that initiated events resulting in death) Last Due to (or as a consequence of): attending physician a for use as the burial-t Physician/Medical Box 68760 IF FEMALE: res, outcome of pregnancy
Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? Month Year 5 Other (specify) Day Pregnant at time of death signed by the sld be detached if 9 Unknown Unknown P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? by Division of Vital Records, 1 Yes 2 No 3 Probably 4 Unknown Completed been s 24b. Were autopsy findings available prior to completion of cause of death? 24a Was an page 2 s has autopsy performe To the Hospital or Attending Physician; The within 24 hours after death.

To the Funeral Director: After this certificate or ompoleted filled in by the funeral director, pag 1 Yes 2 No 25. Was case referred to medica 26. Place of Death (Check only one) Be examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2. No ပ 1 Yes 1 Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 27. Manner of Death 28a. Date of injury (Month, Day, Year) Certificate: 28b. Time of 28c. Injury at 28d. Describe how injury occurred Natural 5 Pending work?
1 Yes 2 🗌 No 2 Accident
3 Suicide
4 Homicide Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

State Registrar

29b. Signature and title of certifier

DEC 23

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

2009

Registrar's Signatu

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene? Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day Month **Physician** Anne Carew Mary 2009 Dec. 17 1015p^M /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City. Town, or Location of Death Examiner Baltimore 17316 Grace Road Hampstead If Under 1 Year | If Under 24 Hrs. Months Days Hours Min. Birthplace (State or Foreign Country) 5. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) **Funeral** Days Months 1 □ M 2 🛣 F **Director** 333-24-8372 2/5/1931 <u>Texaş</u> 78 Usual Residence of Decedent permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, Inc. Medical Examiner must be notified at once. 10d. Inside City Limits 10a. State 10b. County 10c. City, Town or Location 1 ☐ Yes 2X No Director MD Baltimore Hampstead 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number 17316 Grace Road 21074 USA Funeral Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 Never Married 2 Married Baltimore, Maryland 21215-0036 Specify: white 1 ☐ Yes 2 XNo Specify: þ 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Johns Hopkins 12 medical secretary 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Elmer Garbert Margaret Warner ပ္ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 17316 Grace Road, Hampstead, Md. 21074 Walter J. Carew, husband 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 XBurial 2 Cremation 3 Removal from State 12/22/09 4 ☐ Donation 5 ☐ Other (Specify) Hampstead Cemetery Hampstead, Md 21. Signature of Funeral Service 22. Name and Address of Facility Eline Funeral Home M00741 934 S. Main Street, Hampstead, Md 21074 Semmer Approximate Interval Between Onset and Death 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final vicor 14 **Physician** Liver Cancer disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to (or as a consequence of): To the Hospital or Attending Physician: The law requires that the death certificate be executed burial-transit Due to (or as a consequence of): P.O. Box 68760. attending physician for use as the buria Physician/Medical IF FEMALE: If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Month Year 5 Other (specify) 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, þ 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an cate has t page 2 s autopsy performed certificate 1 ☐ Yes 2 ☐ No 1 ☐ Yes 2 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? 1 ☐ Yes 2 No Other: 4 \sum Nursing Home ģ 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 5 Residence 6 ☐ Other (Specify) Certification: To this 28a. Date of Injury (Month, Day, Year) 27. Manner of Death 1 Natural After t 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 5 ☐ Pending investigation 1 □Yes 2 □ No within 24 hours after death.

To the Funeral Director: A completely filled in by the fu 2 Accident 6 ☐ Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical (Check only 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year)

State Registrar

MUL

DHMH 17 Rev 1/2001

nemo

31. Date filed (Month, Day, Year)

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

32. Registrar's Signature

Road Luther ville Ust 21093

Please Type or Print in Black Indelible lnk. Ensure All Copies Are Legible.

			1 _ State	ryland / Depa	artment of F rtificate of I			200	0 12701
			Registrar 1. Decedent's Name (First, Middle, Last)		uncate or i	Jean	2. Date of Dea	Reg. No. ZUU	3. Time of Death
	Physici		Charles Cox				Month	Day Year	7. 12:10 A M
and the	/Medic Examin		4a. Facility Name (If not institution, give street and number)		4b. City, Town, o	Location of Death	1/4	4c. County of Dea	
19.1	, 		Seasons Hospice		Randal]			Baltimor	
	Funeral Director		507 – 42 – 0398 1X м 2□ F	(In yrs. last birthday) 69 Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birt (Month, Day Dec. 20	v, Year) C	rthplace (State or Foreign ountry) WA
	and w		Usual Residence of Decedent 10a. State 10b. County	10c. City, Town or Loc	cation				10d. Inside City Limits
	Maryl f sho	ţo	Maryland Baltimore	Upperco					1 ☐ Yes 2 X No
	h the	Director	10e. Street and Number		10f. Zip Code			10g. Citizen of What C	ountry?
	th wit	ral [15805 Hanover Pike		21155			United Sta	tes
21215-0036	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the "Notice Evar, incr. ust be notified at once.	by Funeral	11. Marital Status 1 Never Married 2 Married 12. Was Decedent E Armed Forces? 1 Myes 2 N If Yes, Give Year or Dates:	0 1900-	Was Decedent of H If Yes, specify Cuba 1 □ Yes 2 🏿 No	ispanic Origin? (Sp un, Mexican, Puerto Specify:	ecify Yes or No- Rican, etc.)	14. Race - Am Black, Whi Specify: W	te, etc.
2-0	72 ho	eted	15. Decedent's Education (Specify only highest grade completed)	16a. Deced	dent's Usual Occup	ation	ina	16b. Kind of Business	/Industry
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20	illed w Hygie ther t int, in		17. Father's Name (First, Middle, Last)	SELVI	ice tecini		First Middle	Maiden Surname)	
aŭ	d be i ental ked o ic eve	To Be	Hugh Verle Cox			Evelyn F			
Maryland	shoul and M s mar umat	-	19a. Informant's Name/Relationship (Type. Print)	19b. Mailin	ng Address (Street			er, City or Town, State,	Zip Code)
Σ	and 2 ealth a n 27 is		Louise Ann Cox - wife	15805	Hanover			, Maryland	21155
altimore,	t of H		20a. Method of Disposition 1 ☐ Burial 2 ☑ Cremation 3 ☐ Removal from State		natory or other plac	e) Dec.	18.	20c. Location - City o	
Ë	t. Pag tmen tant: ijury		4 ☐ Donation 5 ☐ Other (Specify)	Carroll C		2	009	Hampstead,	Maryland
Bal	Depar Impor any ir		21. Signature of Funeral Service Licensee		Name and Address Name Address N		ine Fune et Ham	eral Home ostead, Mai	ryland 21074
			23a. Part1. Enter the disease, or complications that caused shock, or heart failure. List only one cause on each lin-	the death. Do not ente	er the mode of dyir	g, such as cardiac	or respiratory ar	rest,	Approximate Interval Between
	Physician		Immediate Cause (Final disease or condition resulting in death) a. Atherosc	lerotic cardi	orascular	disease			Onset and Death
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68760,	ficate be executed physician and s the burial-transit	edical	d						
P.O. Box 6	The law requires that the death certific ten has been signed by the attending page 2 should be detached for use as to	Physician/Me	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown 1 □ Unknown 23c. If yes, outcome of the past 12 months? 1 □ Live birth 24 □ Pregnant at 25 □ Unknown 25c. If yes, outcome of the past 12 □ Unknown 25c. If yes, outcome of the past 15c. If yes, outcome of th	2 ☐ Fetal death 3 ☐	Ectopic pregnance Other (specify)	/		23d. Date of de Month	elivery Day Year
	res that t signed by be detac	Ph	Part II. Other significant conditions contributing to death bu	t not resulting in the un	nderlying cause give	en in Part I.	23e. Did to	bacco use contribute	to the cause of death?
Division of Vital Records,	quires en sigr uld be	od by					1 □ Y	es 2 No 3 F	robably 4 nknown
ဝ္ဂ	aw require is been się 2 should b	Completed					24a. Was a	an 24b. Were a	utopsy findings available
ž	sician: The law certificate has l irector, page 2 s	mo					autop perfor 1 ∐ Yes	med? _ death?	completion of cause of s 2 □ No
/ita	cian: ertific ector,	Be	25. Was case referred to medical examiner?			26. Place of Deat	n (Check only or	ne) /	
ot	Physi this c	P.		nt 2 ER/Outpatient		er: 4 ☐ Nursing Ho			patient hospice
ū	ding l h. After funer	tion	27. Manner of Death 1 ☑ Natural 5 ☑ Pending (Month, Day,	y 28b. Time of Injury	Work	yat ∵? Yes 2 ∐No	28d. Describe h	ow injury occurred	
ls!	Atten	Certification:	3 Suicide 6 Could not be determined 28e. Place of Injur	ry - At home, farm, stre			28f. Location (S	treet and Number or F	Tural Route Number.
6	al or s after al Dire	erti	4 ☐ Homicide determined building, etc.	(Specify)	•		City or Tow	n, State)	,
	To the Hospital or Attending Physician: within 24 hours after death. To the Funeral Director: After this certifical completely filled in by the funeral director, p	Medical (29a. Certifier (Check only one) Certifying Physician: To the best of 2 Medical Examiner: On the basis of and manner state	examination and/or inv	n occurred at the tir vestigation, in my o	ne, date and place, pinion, death occur	and due to the cred at the time, of	cause(s) and manner a date and place, and du	as stated. e to the cause(s)
		Me	29b. Signature and title of certifier		29c. Licens		- 4	29d. Date signed (Mon	
	AU		► NS KajapakseM.D.		D005	7465		12/17/00	1.
A	UtIVA		30. Name and address of person who completed cause of de N.S. Rajapa VSL, M.D. 25 Ma	ath (Item 23a) (Type, F linst > Swith	Print) e 200/ Re	isterstown	MD :	21136.	
	Sta		31. Date filed (Menth, Day, Year) 32. Registral	aur (nem 23a) (Type, Paris Signature	a Val				
	Registra	ar	BEG 21 2009 Chium	- p. 1900	-				

DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month Day Year December 16, 2009 **Physician** Cooper 0800 Aloise onstance /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Sandy Spring Brook Grove Assisted Living Meadows 1635 Montgomera If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Dec . 11 Birthplace (State or Foreign Country) 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) **Funeral** ^{Year)} 1920 Months Days Hours 1□M 25F 276-14-2549 89 Director Kentucky Usual Residence of Decedent 10d. Inside City Limits 10a. State 10b. County 10c. City, Town or Location 1 ☐ Yes 2 No Montgomery 01ney **Funeral Director** Md. 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 20832 4511 Winding Oak Drive United States 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U,S. Armed Forces? Race - American Indian, Black, White, etc. 1 ☐ Yes 2 X No If Yes, Give Year or Dates: 1 ☐ Never Married 2 ☐ Married 1 ☐ Yes 2 No Specify: Be Completed by Specify: 3 ☑ Widowed 4 ☐ Divorced White 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Homemaker Own Home 12 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Emma Ethel Eddy Vaught Sanders Lionel 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) Jeffrey W. Cooper / Son 4511 Winding Oak Drive, Olney, Md. 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 ☐ Burial 2 🗷 Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Metropolitan Crematory 12/17/09 Alexandria, Va. 22. Name and Address of Facility
Muriel H. Barber Funeral Home 21. Signature of Funeral Service Licensee well H.B Box 5038, Laytonsville, Md. 20882 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. **Physician** Immediate Cause (Final disease or condition resulting in death) /Medical a acute myocardiol intarction Examiner Due to (or as a consequence of): Physician/Medical Examiner coronary arten disease years To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or es a consequence of): Division of Vital Records, P.O. Box 68760, Due to (or as a consequence of): Part II. Other significent conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobecco use contribute to the ceuse of deeth? 1 ☐ Yes 2 ☐ No 3 Probably 4 ☐ Unknown hypertension; hyperlipidemia; Alzheimer's þ 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy Completed disease 22 No 1 ☐ Yes 2 ☐ No 1 ☐ Yes Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) assistedliving Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 Nursing Home 5 Residence 6 HOther (Specify) 1 Yes 2 No Certification: To 27. Manner of Death 28c. Injury at Work? 28d. Describe how injury occurred Natural 5 Pending investigation 1 🗌 Yes 2 🗆 No 2 Accident 3 Suicide 6 Could not be determined 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide **12 Certifying Physicien:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Exeminer: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifier December 16,2009 no attending physician 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 60 Grace Brooke Hoffman, M.D. 18100 Stade School Road Sandy Spring, Maryland 20860 31. Date filed (Month, Day, Year) DEC 18 32. Registrar's Signature State

Registrar

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-09913 Iliam Arthur C	has	Please Type or Print in Black Indelible						ible.				
mam Attror C		1- For State Certificate			i wenta	шпус		a. No. 2	nno	1,279		
Physicia edical Exami	an/	Registrar 1. Decedent's Name (First, Middle,Last) WILLIAM ARTHUR CHASE					Date of Death Month December	1000		Time of Death 2021 hrs		
		Facility Name (if not institution, give street and number) Civista Medical Center		City, Town, or L a Plata	ocation of I	Death		4c. County o	f Death			
Funeral		Social Security Number 6. Sex 7. Age (In yrs. last birthday)	If	Under 1 Year	If Under 2					lace (State or Foreign		
Director		Land	rs.	Months Days	Hours	Min.	JANUARY	12,1958	WASHI	NGION, D.C.		
any		Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Loc	ation						1	0d. Inside City Limits		
/land -f show once.	ţ	MARYLAND CHARLES WALDORF						g. Citizen of Wh		Yes 2 No		
he Mary or 28a ified at	Director	10e. Street and Number 3312 KITCHEN COURT	10	of. Zip Code 20602)			UNITED				
ı with ti ms 23a be noti		11. Marital Status 12. Was Decedent Ever in U.S. 13. V		ecedent of Hisp specify Cuban,	anic Origin		ify Yes or No-		- America	n Indian, Black,		
ter deatl	Funeral	1 Yes 2 X No		s 2 X No		0011011	our, o.o.,	Specify:		ACK		
ours afi atural' xamine	d by	15. Decedent's Education (Specify only highest grade completed) 16a. Decedent	ent's L	Jsual Occupation	on (Give kir			16b. Kind of Bu				
36 nin 72 h E. than "n dical E	Completed by	Elementary/Secondary (0-12) College (1-4 or 5+)		CTION I			,	CONSTR	UCTI	ON		
21215-0036 and be filed within 7 Mental Hygiene. marked other than c event, the Medica		17. Father's Name (First, Middle, Last)		1	8.Mother's	Name (F		laiden Surname)				
2121 uld be fi Mental marked	То Ве	THOMAS JEROME CHASE, SR. 19a. Informant's Name/Relationship (Type, Print) 19b. Mail	ing Ad					BUTLER C ber, City or Tow		Zip Code)		
MD d 2 shoulth and n 27 is aumatic	DOROTHY WASHINGTON / SISTER 3312 KITCHEN COURT, WALDORF, MARYLAND 20602											
		20a. Method of Disposition 20b. Place of Disposition 1 X Burial 2 Cremation 3 Removal from State	other	place)			Date	20c. Location -	•			
Baltimore, permit. Pages I are Department of Hee Important: If iteningury or other tr		4 Donation 5 Other Specify: 21 Agnature of Funeral Services Licenses							r, MA	KYLAND		
		LYDIA C. THORNION JOHNSON MOOS83 1 HORNTON FUNERAL HOME, P.A. 3439 LIVINGSTON ROAD, INDIAN HEAD, MARYLAND 2064										
Physician /Medical		failure. List only one cause on each line.	runen	node of dying, s	such as can	diac or i	espiratory arre	st, shock, or her	310	Approximate Interval Between Onset and Death		
xaminer		Immediate Cause (Final disease or condition resulting in death) Due to (or as a consequence of):										
	ner	Sequentially list conditions, if any, leading to immediate Due to (or as a consequence of):										
_	Examine	cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last C. Due to (or as a consequence of):	_									
executed an and al - transit	=	d. UNPENDED AMENDED						_				
	Medi	IF FEMALE: 23c. If yes, outcome of pregnancy						23d. Date of	delivery			
Box 68760, c death certificate be exe the attending physician of for use as the burial	cian/	23b. Was decedent pregnant in the past 12 months? 1 Live birth 2 4 Pregnant at time of death 5	Fetal o	death 3 (Specify)	Ectopic	oregnand	СУ	Month	Da	y Year		
BOy he death the atte	Physician/Medica	1 Yes 2 No 9 Unknown g Unknown			ives in Port		23e Did to	hacco use contr	ibute to th	e cause of death?		
tal Records, P.O. Box 68760, cian: The law requires that the death certificate be certificate has been signed by the attending physici ector, page 2 should be detached for use as the buri	by	Part II. Other significant conditions contributing to death but not resulting in the	e una	enying cause g	ivei ili rait					bly 4 Unknown		
ords, w requir s been s should!	Completed						24a. Was a autop	sy	prior to co	psy findings available mpletion of cause of		
Reco	Comp						1 ✔ Yes		death? Yes	2 No		
Vital ysician: his certif director,	Be	25. Was case referred to medical examiner? 1 ✓ Yes 2 No Hospital: 1 Inpatient 2 ✓ ER/Outpati	ent 3		of Death (C			Residence 6	Other:			
Division of Vital Records, P.O. rat or Attending Physician: The law requires that the stater death. The Director: After this certificate has been signed by led in by the funeral director, page 2 should be detaed in by the funeral director, page 2 should be detaed.	on: To	27. Manner of Death 28a. Date of Injury 28b. Time	of Injur		y at Work?	S	8d. Describe I	now injury occurs	red			
Natural 5 Pending Investigation 2 Accident Investigation 3 Accident Investigation 2 Accident Investigation 3 Accident Inv										al Route Number, City		
Div pital or ours afte eral Di	Certification:	Suicide 6 Could not be determined (Specify) Single Family				9	or Town, S 950 Bunker I	itate) Hill Road , Wa	ldorf , M	D		
Division of Norther Hospital or Attending Phywithin 24 hours after death. To the Funeral Director: After the completely filled in by the funeral	Medical	29a. Certifier (Check only one) Certifying Physician: To the best of my knowledge, death or one) Wedical Examiner: On the basis of examination and/or invest	curred gation	l at the time, da , in my opinion	ate and plac , death occi	e, and d urred at	ue to the caus the time, date	e(s) and manne and place, and o	r as stated due to the	d. cause(s)		
To To con	Mec	and manner stated. 29b. Signature and title of certifier		29c. Licens	e number			29d. Date sign	ned (Mont	th, Day, Year)		
		Men Brasse Y. MD		0.C.I	M.E.			December	22, 20	9		
B31		Name and address of person who completed cause of death (Item 23a) Melissa Brassell, MD	Per	nn Street, B	altimore	, MD 2	1201					
S Regis	tate trar	31. Date filed (Month Pery, Year) 2009 32. Registrar's Signature	ach	Lad								
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DHMH 17 Rev 1/2001 OCME 2006

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29a. Certifier (Check only one) 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier (Check only one) 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 30. Name and address otherson who completed cause of death (Item 23a) (Type, Print) Check for Name and address otherson who completed cause of death (Item 23a) (Type, Print) Check for Name and address otherson who completed cause of death (Item 23a) (Type, Print) Check for Name and address otherson who completed cause of death (Item 23a) (Type, Print) Check for Name and address otherson who completed cause of death (Item 23a) (Type, Print) Check for Name and address otherson who completed cause of death (Item 23a) (Type, Print) Check for Name and address otherson who completed cause of death (Item 23a) (Type, Print) Check for Name and address otherson who completed cause of death (Item 23a) (Type, Print) Check for Name and address otherson who completed cause of death (Item 23a) (Type, Print) Check for Name and address otherson who completed cause of death (Item 23a) (Type, Print) Check for Name and address otherson who completed cause of death (Item 23a) (Type, Print) Check for Name and address otherson who completed cause of death (Item 23a) (Type, Print) Check for Name and address otherson who completed cause of death (Item 23a) (Type, Print) Check for Name and address otherson who completed cause of death (Item 23a) (Type, Print) Check for Name and address otherson who completed cause of death (Item 23a) (Type, Print) Check for Name and Address otherson who completed cause of death (Item 23a) (Type, Print)	5	g Phyter thi	Ë			28a. Date of Inj	ury	28b. Time o			L realising	1			/
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DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Day Month Minnie Travis Story Cronshaw 15, 2009 December 8:04 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City. Town, or Location of Death Kent Heron Point Chestertown If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) Days Hours Months 1 □ M 2 🛣 F 94 6/24/1915 216-09-7774 Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10b. County 1X Yes 2 □ No Kent Chestertown 10e. Street and Number 10g. Citizen of What Country? 10f. Zip Code 501 E. Campus Ave - Heron Point 21620 USA 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc 1 ∐Yes 2 X No If Yes, Give Year or Dates: 1 Never Married 2 Married 1 □ Yes 2 X No Specify Specify: White 3 X Widowed 4 □ Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) 12 College (1-4or 5+) Owner/Operator Lumber 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Amelia Wessel John Story 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Thomas McGlinn 7280 Swan Creek Rd. Rock Hall, MD 21661 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 Burial 2 ☐ Cremation 3 ☐ Removal from State 4 Donation 5 Dother (Specify) Sudlersville Cemetery 12/19/09 Sudlersville, MD 21. Signature of Funeral Service Licenses 22. Name and Address of Facility Fellows, Helfenbein & Newnam Funeral Home 130 Speer Rd. Chestertown, MD 21620

Physician /Medical **Examiner**

Physician

/Medical

Examiner

10a. State

MD

Funeral

Director

28a-f show

23a or

'natural", or

Health and Mental Hygi em 27 is marked other

permit. Pages 1 and 2 s Department of Health ar Important; If item 27 is any injury or other trau once.

1 and 2 should be

the Medical Examiner must be notified at

Director

Funeral

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Completed

Be

2

filed within 72 hours after death with the Maryland

Baltimore, Maryland 21215-0036

requires that the death certificate be executed

Examine sician and burial-trans Physician/Medical signed by the a ģ Be Completed page 2 s Certification: To o 24 hours after death.

e Funeral Director: After thi letely filled in by the funeral (Medical within 24 hor To the Fune completely fi

29a. Certifier

(Check only

HELTON

29b. Signature and title of certifier

31. Date filed (Month, Day, Year)

Division of Vital Records, P.O. Box 68760,

Hospital or Attending Physician: The law

the

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shock, or heart failure. List only one		,			imate I Between and Death
Immediate Cause (Final disease or condition	ALZHEIMERS DISE	ASE (END S	TAGE)	>10	
resulting in death)	Due to (or as a consequence of):				j
Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events	Dus to (or as a consequence of):				
that initiated events c. resulting in death) Last	Due to (or as a consequence of):				
IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 Yes No 9 Unknown	3c. If yes, outcome of pregnancy 1 □ Live birth 2 □ Fetal death 3 □ Ectopi 4 □ Pregnant at time of death 5 □ Other 9 □ Unknown	ic pregnancy (specify)		23d. Date of delivery Month Day	Year
Part II. Other significant conditions cont	tributing to death but not resulting in the underlying	g cause given in Part I.	23e. Did tobacco	use contribute to the cause	e of death?
			24a. Was an autopsy performed?	24b. Were autopsy find prior to completion death?	of cause of
25. Was case referred to medical examiner?		26. Place of De	ath (Check only one)		
1 Yes 2No	ospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐	DOA Other: Nursing H	Home 5 ☐ Residence	6 ☐ Other (Specify)	
27. Manner of Death 1 Natural 5 ☐ Pending 2 ☐ Accident investigation	28a. Date of Injury (Month, Day, Year) 28b. Time of Injury M	28c. Injury at Work? 1 □Yes 2 □ No	28d. Describe how inju	ry occurred	
3 ☐ Suicide 6 ☐ Could not be 4 ☐ Homicide determined	28e. Place of Injury - At home, farm, street, fact building, etc. (Specify)	ory, office	28f. Location (Street a City or Town, Sta	nd Number or Rural Route e)	Number,

TSCertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)

29c. License number

00041587

29d. Date signed (Month, Day, Year)

SPEER RD. CHESTERTOWN, MD 21620

12-16-2009

DHMH 17 Rev 1/2001

State Registrar 122

and manner stated.

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

DHMH 17 Rev 1/2001

State Registrar 31. Date filed (Month, Day,

Year)

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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death December 19 2009 1:10 a M Fei-Fei 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Holy Cross Hospital Silver Spring Montgomery If Under 1 Year | If Under 24 Hrs. 6. Sex Birthplace (State or Foreign Country) 5. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Hours 1 □ M 2 👿 F 440-78-1667 54 09/20/1955 Hong Kong Usual Residence of Decedent 10b. County 10c. City, Town or Location 10d. Inside City Limits 1 ☐Yes 2 No Silver Spring Maryland Montgomery 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number 20902 U.S.A. 1943 Westchester Drive 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 11. Marital Status 14. Race - American Indian, Black, White, etc. 1 ∐Yes 2 ☑ No If Yes, Give Year or Dates: 1 Never Married 2 Married 1 ☐ Yes 2 🗶 No Specify Specify: 3 Widowed 4 Divorced Asian 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) **5**+ Law Firm Attorneu 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Unknown Unknown 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Fred J. Chen - Spouse 1943 Westchester Drive, Silver Spring, MD 20902 20a. Method of Disposition 20c. Location - City or Town, State Place of Disposition (Name of cemetery, crematory or other place) Date 1 ☐ Burial 2 又 Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Lincoln Crematory 12/29/2009 Brentwood, Maryland 21. Signature of Funeral Service Licensee 22. Name and Address of Fecility Hines-Rinaldi Funeral Home, Inc.

Physician /Medical Examiner

Department of Health an Important: If item 27 is any Injury or other trau

Pages

Physician

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28a-f show

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27 is marked other than "natural", or items 23a or 28a-f shor traumatic event, the Madical Eventions

ene. than "natural", or

12 should be filed what and Mental Hygie 7 is marked other the

vithin 72 hours after death

Baltimore, Maryland 21215-0036

Examine

attending physician and for use as the burial-transi Physician/Medical certificate has been signed by the rector, page 2 should be detached Completed by Be Certification: To After thi funeral ours after death.
neral Director: Ai
filled in by the fu To the Hospital o within 24 hours af To the Funeral Di

Division of Vital Records, P.O. Box 68760

, ,	Warmel 11181	00 New Hampshire	Ave., Silver Spr	ung, MV 2091						
shock, or heart failure. List or	emplications that caused the death. Do not enter to one cause on each line.	he mode of dying, such as cardiac or	respiratory arrest,	Approximate Interval Between Onset and Death						
Immediate Cause (Final disease or condition	Pneumonia	Pneumonia								
resulting in death)	Due to (or as a consequence of):									
Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury	b	b								
that initiated events resulting in death) Last	Due to (or as a consequence of):									
IF FEMALE:	V.									
23b. Was decedent pregnant in the past 12 months? 1 ∐Yes 2 ፟፟∭No 9 ☐ Unknown		ctopic pregnancy ther (specify)	23d. Date of o	delivery Day Year						
	s contributing to death but not resulting in the under	rlying cause given in Part I.	23e. Did tobacco use contribute	to the cause of death?						
<u> </u>			1 □ Yes 2 🛣 No 3 □	Probably 4 Unknown						
Multidrug Re	sistent Pseudomenas		24a. Was an 24b. Were	autopsy findings available to completion of cause of						
Stroke			performed? death	to completion of cause of ? es 2 No						
25. Was case referred to medical examiner?		26. Place of Death	(Check only one)							
1∐ Yes 2 🛣 No	Hospital: 1 ☑ Inpatient 2 ☐ ER/Outpatient	3 ☐ DOA Other: 4 ☐ Nursing Hom	e 5 Residence 6 Other (S	pecify)						
27. Manner of Death 1 ☑ Natural 5 ☐ Pending 2 ☐ Accident investigat	28a. Date of Injury (Month, Day, Year) 28b. Time of Injury		Bd. Describe how injury occurred							
3 ☐ Suicide 6 ☐ Could not 4 ☐ Homicide determine		factory, office	Bf. Location (Street and Number or City or Town, State)	Rural Route Number,						
29a. Certifier 1 🔀 Certifying (Check only one)	Physician: To the best of my knowledge, death oc aminer: On the basis of examination and/or invest and manner stated.	curred at the time, date and place, a ligation, in my opinion, death occurre	nd due to the cause(s) and manner d at the time, date and place, and d	as stated. lue to the cause(s)						
29b. Signature and title of certifier		29c. License number	29d. Date signed (Mo	nth, Day, Year)						

Registrar

State

completely

Medical

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30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

M.D.,

Yodit Negusse.

DEC 23

31. Date filed (Month, Day, Year)

D69288

1500 Forest Glen Road, Silver Spring, Maryland 20910

December 21, 2009

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registra Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month Juana Carrera M_ Dec.17 2009 3:28a 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Death 8712 Colesville Road #5 Silver Spring Montgomery 9. Birthplace (State or Foreign Country) 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) Months Days Hours Min 1 M 2 D F Ecquador 216-82-2011 90 Usual Residence of Decedent 10b. County 10c. City, Town or Location 10d. Inside City Limits 1 ☐ Yes 2 TNo Montgomery Silver Spring 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 8712 Colesville Road #5 20910 Ecuador 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☐ No If Yes, Give Year or Dates: 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. 1 Never Married 22 Married 1 Tyes 2 □ No Specify: Ecuador White 3 Widowed 4 Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Homemaker Own Home 12 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Federico Reyes Ercilia Cepeno 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 20910 Carlos R.Carrera/Husband 8712 Colesville Road #5 Silver Spring, Md 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 1 Burial 2 ☐ Cremation 4 ☐ Donation 6 ☐ Other (Maryland Nat.Mem.Pk 12/28/2009 Laurel,Md. # ☐ Other (Specify)# PHILIPADS RIWALDI FUNERAL SERVICE, P.A. 9241 Columbia Blvd.Silver Spring, Md20910 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death HEP ATOCELLUM CARCINOMA Immediate Cause (Final

Physician /Medical Examiner

signed by the a

page 2

director funeral

ithin 24 hours after death.

the Funeral Director: Aformpletely filled in by the fur

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23a or

or items

"natural",

Department of Health and Mental Hygien Important: If Item 27 is marked other that any Injury or other traumatic event, Item 2000.

traumatic event, the Medical Exactions must be restified at

72 hours after death with the Maryland

Baltimore, Maryland 21215-0036

Division of Vital Records, P.O. Box 68760.

the Hospital or Attending Physician: The

cian/Medical Examiner law requires that the death certificate be execute burial-tran attending physician for use as the buria

resulting in death)	Due to (or as a consequence of):	,	
Sequentially list conditions, if any, leading to immediate cause. Enter Underlying	b. Due to (or as a consequence of).		
Cause (Disease or injury that initiated events resulting in death) Last	c		
IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2√ 10 9 □ Unknown	23c. If yes, outcome of pregnancy 1		23d. Date of delivery Month Day Year
Part II. Other significant conditio	ns contributing to death but not resulting in the underlying cause given in Part I.	23e. Did tobacco	use contribute to the cause of death?
		24a. Was an autopsy	24b. Were autopsy findings available prior to completion of cause of

9 Unknown		9 🗆 Unknown		()		
Part II. Other signifi	cant conditions	contributing to death but not res	sulting in the underlying	g cause given in Part I.	23e. Did tobacco u 1 □ Yes 2	se contribute to the cause of death?
					24a. Was an autopsy performed? 1 □ Yes 2 ₩ No	24b. Were autopsy findings available prior to completion of cause of death? 1 □ Yes 2 □ No
25. Was case referrexaminer?	ed to medical			26. Place of De	eath (Check only one)	
1 Yes 2 X	No	Hospital: 1 ☐ Inpatient 2 ☐	ER/Outpatient 3 □	DOA Other: 4 Nursing	Home 5 → Residence 6	3 ☐ Other (Specify)
27. Manner of Death 1 ☑ Natural 2 ☐ Accident	5 ☐ Pending investigation		28b. Time of Injury	28c. Injury at Work? 1 □ Yes 2 □ No	28d. Describe how injury	y occurred
3 ☐ Suicide 4 ☐ Homicide	6 ☐ Could not b determined		iome, farm, street, factorify)	ory, office	28f. Location (Street and City or Town, State)	d Number or Rural Route Number,
29a. Certifier (Check only one)	1 CertifyIng Ph 2 Medical Exam	nysician: To the best of my kn miner: On the basis of examin and manner stated.	owledge, death occurre ation and/or investigati	ed at the time, date and pla on, in my opinion, death oc	ce, and due to the cause(s) curred at the time, date and	and manner as stated. place, and due to the cause(s)

29c. License number

29d. Date signed (Month, Day, Year)

Dec.22,2009

State Registrar

Victor M.Priego M.D. 31. Date filed (Month, Day, Year)

DEC 23

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

29b. Signature and title of certifier

6420 32/Registrar's Signature

Rockledge Dr. #4100 Rckville, Md.

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State
RegistrarAMEND#20bperFH, 12/29/09 AWWM Gertificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Month Year AC М Medical 4a. Facility Name (if not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death Examiner Montgomery Takoma Park Washington Adventist Social Security Number If Under 1 Year If Under 24 Hrs. 7. Age (In yrs. last birthday) 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** 1 🗆 M 2 🔀 F Months Days Hours Min. Nov. 17, 1954 55 Colombia 216-43-7163 Director Usual Residence of Decedent Mental Hygiene. narked other than "natural", or items 23a or 28a-f show atic event, the Medical Examiner must be notified at permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified ** once. 10a. State 10c. City, Town or Location 10d. Inside City Limits Director MD Montgomery Silver Spring 1 Yes 2 X No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 20910 408 Mississippi Avenue Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☒ No If Yes, Give Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian. Black, White, etc. Completed by 1 Never Married 2 Married Baltimore, Maryland 21215-0036 Specify: White 1∑Yes 2□No Specify: Colombian 3 Widowed 4 Divorced Year or Dates 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) Teacher University Be 18. Mother's Name (First, Middle, Maiden Surname)
Ana Tulia Moreno 17. Father's Name (First, Middle, Last) Herman Camacho 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 20910408 Mississippi Avenue Silver Spring, Md Alvaro Rincon/Son 20a. Method of Disposition Date 29-2009 20b. Place of Disposition (Name of 20c. Location - City or Town, State cemetery crematory or other place) Jardines dei Recuerdo de Paz 1 🔀 Burial , 2 🗌 Cremation, 3 🔀 Removal from State Bogota, Colombia 4 Donation 5 Other Specify) 30/20d9 21. Signature of Funeral Se 761 4th Avenue Brooklyn,NY11232 22. Name and Address of Facility Yules Las Rosas Funeral Home 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between Onset and Death shock, or heart failure. List only one cause on each line Immediate Cause (Final Physician disease or condition resulting in death) Medical Due to (or as a consequence of) Examiner ACTEREMIA Sequentially list conditions. Examine if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Due to (or as a consequence of) To the Hospital or Attending Physician: The law requires that the death certificate be executed the burial-transi PENL and that initiated events resulting in death) Last Due to (or as a consequence of) physician Physician/Medical CME MOTHER Division of Vital Records, P.O. Box 68760 for use as attending IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant Ectopic pregnancy in the past 12 month Month Day Year 5 Other (specify) Pregnant at time of death ed by the a detached f a 🗌 Unknown 9 Unknown signed t Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 Yes 2 No 3 Probably 4 Unknown within 24 hours after death.

To the Funeral Director: After this certificate has been signompleted filled in by the funeral director, page 2 should to 24b. Were autopsy findings available 24a. Was an prior to completion of cause of death?
1 ☐ Yes 2 ☐ No autopsy Be 25. Was case referred to medical 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 4NO မ 1 Yes 1 I Impatient 2 I ER/Outpatient 3 DOA Certificate: 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred 5 Pending Natural injury 1 ☐ Yes 2 ☐ No ☐ Accident Investigation Suicide 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, determined City or Town, State) Medical 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

| Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
| Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier (Check 29c. License number 29b. Signature and title of ce 29d. Date signed (Month, Day, Year)

State Registrar

3

30. Name and address of person who completed cau

23

2009

31. Date filed (Month, Day, Year)

7600 Carroll Ave. Takoma Park, Md

e of death (Item 23a) (Type, Print)

. Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

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State of Maryland / Department of Health and Mer	ntal Hygien	009

		,	1 - For State Registrar	State of Maryla		artment rtificate			nd Mer		ene ()	09	428	03
	Physici		1. Decedent's Name (First, Middle, La: Elizabeth W.	Cooper			-			Date of Death Month ecembe		2009	3. Time of 0	Death M
	/Medic Examir		4a. Facility Name (If not institution, giv 26985 Pratt Road			Sal	isbur	У	Death		4c. Cou	nty of Death		
	Funeral Director		5. Social Security Number 6. S 220–12–1017 1 Usual Residence of Decedent	ex 7. Age (In yr.	s. last birthday) Yrs.	If Under Months		Under 24 Hours N	Hrs. 8. Min. 1	Date of Birth (Month, Day, $1/10/1$)	^{Year)} 924	Cou	place (State or ntry) Land	Foreign
	Maryland a-f show	ctor	10a. State 10b. County Maryland Wicomi		City, Town or Lo Salisbur						,	1	10d. Inside City 1 □ Yes	
	h with the	al Dire	10e. Street and Number 26985 Pratt Ro	ad		10f. Zip	Code 21801			10	0	of What Cour SA	ntry?	
9800	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Dipertment of Health and Mental Hyglene. Important: if Item 27 Is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Evaminar must be notified at other.	d by Funeral Director	11. Marital Status 1 Never Married 2 Married 3 X Widowed 4 Divorced	12. Was Decedent Ever in Armed Forces? 1		Was Deceder If Yes, special		anic Origin Mexican, P Specify:	? (Specify uerto Rica	/ Yes or No- an, etc.)		Race - Americ Black, White, cify: w		
21215-0036	filed within 72 ho Hygiene. yther than "natu ent, In Medical	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) Collage (1-4or 5+) Collage (1-4or 5+) Collage (1-4or 5+) Nurse 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) nurse he									f Business/In			
Maryland	2 should be filed within and Mental Hygiene. Is marked other than aumatic event, Ire Man	To Be (17. Father's Name (First, Middle, Last) Charles B. Wall	s				Hele	en Hu	irst, Middle, M bbard				
Ž	1 and 2 sh Health and tem 27 is m		19a. Informant's Name/Relationship (Ann King/daughte							oute Number,			o Code)	
Baltimore,	permit. Pages 1 Department of H Important: If Iten any injury or oth		20a. Method of Disposition 1 Burial 2 □ Cremation 3 □ 4 □ Donation 5 □ Other (Specified)	Removal from State W:	Place of Dispo cemetery, cred COMICO Park	nsition (Name matory or othe Memor	ne of her place) Cial	1,	Date 2/10/			on - City or To Sbury,		
Balt	permit. Departi Importa any inju		21. Signature of Funeral Service Licer			2. Name and HOLIC	d Address o	Facility unera ill F	al Ho	me Pro Salisb	fessi ury,	onal A MD 218	Associat 804	tion
and a	Physician /Medical		23a. Part 1. Enter the disease, or com shock, or heart failure. List only Immediate Cause (Final disease or condition resulting in death)	plications that caused the de one cause on each line. a. Due to (or as a conse		ter the mode	e of dying, s	uch as car	rdiac or re	espiratory arre	st,		Approximate Interval Betw Onset and Do	veen
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68760,	ate be executed hysician and the burial-transit	ical Examiner	Cause (Disease or injury that initiated events resulting in death) Last	c. ASCUS Due to (or as a conse										
P.O. Box 68	Physician: The law requires that the death certificate be executed this certificate has been signed by the attending physician and rall director, page 2 should be detached for use as the burial-transit	Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □Yes 2 □No 9 □ Unknown	23c. If yes, outcome of preg 1 ☐ Live birth 2 ☐ Fe 4 ☐ Pregnant at time o 9 ☐ Unknown	tal death 3[☐ Ectopic pr ☐ Other (spe						Date of deliv Month		'ear
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Il Records,	: The law re cate has be page 2 sho	Completed					_		-	24a. Was an autopsy perform 1 □ Yes 2	ed?	Ib. Were auto prior to co death? 1 ☐ Yes	opsy findings a ompletion of ca 2 No	vailable use of
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of	Phys	은	1 ☐ Yes 2 ☑ No 27. Manner of Death	1 ☐ Inpatient 2	☐ ER/Outpatie		A			5 X Resider			f(y)	
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ō	To the Hospital or Attendin within 24 hours after death. To the Funeral Director: Af completely filled in by the fur		4 Homicide determined	28e. Place of Injury - At building, etc. (Spen				data and r		City or Town,	State)			
	n 24 ho n 24 ho ne Fun pletely	Medical		niner: On the basis of exami and manner stated.	nation and/or ir	vestigation,	in my opini	on, death	occurred :	at the time, da	ite and plac	ce, and due t	to the cause(s)	
	within to the state of the stat	Me	29b. Signature and title of certifier	te.			License nu		55	29		ned (Month,	Day, Year)	
	es of		30. Name and address of person who		em 23a) (Type,		2 (al)	s book	mn -	21180 U		, ,		
	Sta		31. Date filed (Month, Day, Year)	32. Registrar's Sig		/	Ju, 11	71						

DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death December 13, 2009 **Physician** 1:30 A M Donnelly Marie Rose /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Homewood at Crumland Farms Frederick Frederick If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) Aug. 1, 1932 . Social Security Number 6. Sex 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign **Funeral** Days Hours Min. 1 □ M 2 ₩ F Months Connecticut 77 048-26-3134 Director Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10a State 10h. County ral", or items 23a or 28a-f show Examiner must be notified at ¥ Yes 2 □ No Director Frederick Frederick Maryland 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 21702 United States 1768 Harvest Drive Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ∑ No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 Never Married 2 Married natural", or 1 ☐ Yes 2 No Specify 3 Widowed 4 Divorced White 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) and 2 should be filed within 'ealth and Mental Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) Pharmacist **Healthcare** 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Maryland Be Lorita Mauro Pasquale Fiorino 2 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Important: If item 27 is any injury or other tra once, Paul Donnelly / Husband 1768 Harvest Court, Frederick, MD 21702 Baltimore, 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition 1 XBurial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 12/23/2009 Cranston, Rhode Island Ann's Cemetery 1
22. Name and Address of Facility 21. Signature of Funeral Service Licensee Stauffer Funeral Home 23a. Part inter the dise se or complications that field the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure list only one cause on each line. 1621 Opossumtown Pike, Frederick, MD 21702 Immediate Cause (Final disease or condition resulting in death) As Money **Physician** /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examine ARFLASON Due to (or as a consequence of): Physician/Medical attending plant for use as IF FEMALE 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 4☐Pregnant at time of death 5 ☐ Other (specify) P.0. 9 Unknown 9 Unknown signed by t the detach 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Vital Records, 2 No 3 Probably 4 Unknown 1 🗌 Yes Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a Was an page 2 s autopsy performed? Yes 2 No 1□ Yes 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Be Other: 4 Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 2 No 2 1 Tyes 1 Inpatient 2 ER/Outpatient 3□ DOA Oct MDivision or 27. Manny of Death 1 Vatural 28c. Injury at Work? 28a. Date of Injury (Month, Day Year) 28b. Time of 28d. Describe how injury occurred Certification; 5 ☐ Pending investigation Injury 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be determined 3 Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide within 24 hours a To the Funeral D 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical (Check only 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. one) 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Joseph Ashwal, MD 56 TJ Drive, Frederick, MD 21702 31. Date filed (Month, Agr. Year) 32. Registrar's Signature State 8

DHMH 17 Rev 1/2001

Registrar

: 12-13-09

Dennelly

Physician

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene 2009 4 2805

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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. 2009 42806 State of Maryland / Department of Health and Mental Hygiene

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Baltimore, MD 21215-0036 permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland pepartment of Realth and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show injury or other traumatic event, the Medical Examiner must be notified at once.	al Director	2316 Brightseat Road #7	20785	1	U. S. A.	
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213 ould b d Men s mar		19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Addres	s (Street and Number or Ru	ral Route Number,	City or Town, State,	Zip Code)
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St Regist	:100	31. Date filed (Month, Day, Year) JAN 0 5 2010 32. Registrar's Signature Authority				
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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2 Date of Death 1 Decedent's Name (First Middle Last) 3. Time of Death Year **Physician** DIXON 3:50 PM ZENER 12 2009 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** PRINCE MAGNOHA GEORGES NURSING HOME Lanham 5. Social Security Number If Under 1 Year If Under 24 Hrs. Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) 6. Sex 8. Date of Birth (Month, Day, Year) **Funeral** Months Days Hours 579-62-7258 100 M 2□ F ケ Director 01/11/1952 Washington, IC Usual Residence of Decedent 10a. State 10c. City, Town or Location 10d. Inside City Limits Hygiene. other than "natural", or items 23a or 28a-f show ent, the Modical Exanimen must bun sufficial at 1 Tyes 2 □ No Director MO Charles Waldorf 10e. Street and Number 10g, Citizen of What Country? 10f. Zip Code 2051 Tanglewood Drive 20601 U.S.A. Completed by Funeral filed within 72 hours after death 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S Armed Forces? 14. Race - American Indian, 11 Marital Status Black White etc. 1 ☐ Never Married 2 ☐ Married 1 □Yes 2 No Baltimore, Maryland 21215-0036 If Yes, Give Year or Dates: 1 ☐ Yes 2 ▼ No Specify: Black 3 ☐ Widowed 4 ☑ Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Unemployed 2 years and Mental Hygi 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Department of Health and Menta Important: If item 27 Is marked any injury or other traumatic evonce. Ruth Lewis Zener Dixon, Sr. ပ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Cail D. Pearson, MD - Sister 1229 15th Street, N.W.; Washington, D.C. 20005 Pages 1 a 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 Donation 5 Dother (Specify) Chesapeake Crematory 12/26/2009 Beltsville, MD 22. Name and Address of Facility Freeman Fuheral Services 21. Signature of Funeral Service Licenses Reenai 4594 Beech Road; Temple Hills, Maryland 20748 23a. Part 1 Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, of heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final CEREBROVASCULAR ACCIDENT ACUTE DAYS Physician disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner UNKNOWN HYPERTENSION Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examine burial-transi requires that the death certificate be executed Due to (or as a consequence of): Box 68760. attending physician Physician/Medical the 38 IF FEMALE use a ves, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant 1 ☐ Live birth 2 ☐ Fetal death 4 ☐ Pregnant at time of death 3 Ectopic pregnancy in the past 12 months? Day 5 Other (specify) P.O. 1 Tyes 2 TNo 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? of Vital Records, þ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☑ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an perform certificate 1 ☐ Yes 2 ☐ No 1 Yes 2 🗓 To the Hospital or Attending Physician: 25. Was case referred to medical examiner? Be 26. Plage of Death (Check only one) Hospital: 1 Yes 2 No Other: 4 M Nursing Home 5 Residence 6 Other (Specify) 1 Inpatient 2 ER/Outpatient 3 DOA this Certification: To funeral 27. Manner eath 28b. Time of 28a. Date of Injury (Month, Day, Year) 28d. Describe how injury occurred After Division 5 ☐ Pending investigation within 24 hours after death.

To the Funeral Director: A
completely filled in by the fu 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by determined 4 Homicide 1 Dertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a, Certifier Medical 29b. Signature and title of certifier 29c. License number

DHMH 17 Rev 1/2001

State

Registrar

HINA

31. Date filed (Month, Day, Year)

DEC 2 8 2009

SYED, M.D

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

7525 GREENWAY CTL PRIVE) SUICE 105,

32. Registrar's Signature

D0063978

2009

GREENBELT, MD 20770

Please Type or Print in Black Indelibled 1/2 Insert All Copies Are Legible.

Amend Item 24a per phys. State of Maryland / Department of Health and Mental Hygiene On One Certificate of Death Reg. No. 2. Date of Death 1. Decedent's Name (First, Middle, Last) 3. Time of Death Day **Physician** Year Gilbert Dean 0342 2009 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Salisbury

If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 27494 Riverside Drive Wicomico 9. Birthplace (State or Foreign Country) 5. Social Security Number 7. Age (In yrs. last birthday) Funeral 1 XM 2 ☐ F 3-13-1937 Director 214-32-7126 72 MD Usual Residence of Decedent with the Maryland 10a. State 10c. City, Town or Location 10d. Inside City Limits •how 10b. County item 27 is marked other than "naturel", or items 23a or 28a-f sho other traumatic event, the Modical Examinations ust be notified at 1 XYes 2 No Directo MD Wicomico Salisbury 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code Funeral 27494 Riverside Drive 21801 14. Race - American Indian, 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Black, White, etc. filed within 72 hours after 1 ☐ Yes 2 ☐ No If Yes, Give Year or Dates: 1 Never Married 2 Married 1 ☐ Yes 2 X No Specify: δ Specify: 3 Widowed 4 Divorced White Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Hygiene. Gene's Taxi Taxi Driver 8 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be and Mental Rozena Duck ဥ Victor Dean 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Pamela Contreras/Daughter 27494 Riverside Dr., Salisbury, Mp 21501 item 27 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition ō 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State = 5 Department of Importent: if any injury or once. 4 ☐ Donation 5 ☐ Other (Specify) Direct Crematory, 12-18-2009 Dover, DE 21. Signature of Fineral Sen 22. Name and Address of Facility Pennie Smith 917 W. Isabella St Part 1 filer the disease, or complications the caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart afflure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** METASTATIC LUNG CANCER /Medical Due to (or as a consequence of): Examiner COPD Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Due to (or as a consequence of) The law requires that the death certificate be executed physicien and s the burial-transit Exami CAD resulting in death) Last Due to (or as a consequence of): Completed by Physician/Medical HYPERLIPIDEMIA nding p IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant in the past 12 months?
1 □ Yes 2 □ No 23d. Date of delivery atten for u 3 Ectopic pregnancy Month 4☐Pregnant at time of death 5 Other (specify) signed by the a d be detached for 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 1 Yes 2 No 3 Probably 4 Unknown 24a. Was an autopsy performed? 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 2□ No 2**X** No 1 ☐ Yes or Attending Physician: : After this certification of funeral director. Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA 1 ☐ Yes 2 No Other: 4 Nursing Home 5 Aesidence 6 Other (Specify) Certification; To 28c. Injury at Work? 28a. Date of Injury (Month, Day Year) 28b. Time of Injury 27. Manner of Death 28d. Describe how injury occurred 1 Natural 5 Pending investigation death. 1 ☐ Yes 2 ☐ No after death Director: / d in by the f 2 Accident 6 □ Could not be 3 🗌 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide To the Hospital o within 24 hours aff To the Funeral Di completely filled in 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Exeminer: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 29c. License number

Division of Vital Records,

.O. Box 68760,

۵.

Baltimore, Maryland 21215-0036

State

Registrar

DHMH 17 Rev 1/2001

32. Registrar's Signature

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

JOY MADARANG - LEWIS

31. Date filed (Month, Day, Y

050929

1405 S. OIVISION ST. SAUSBURY MO 21804

12-16-09

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 3. Time of Death 4:15P. M 1. Decedent's Name (First, Middle, Last) 2. Date of Death DiCamillo 21. 2009 Angela Maria December 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Montgomery Silver Spring Arden Courts If Under 1 Year | If Under 24 Hrs. 8. Date of Birth Nov • 27, 1922 9. Birthplace (State or Foreign 5. Social Security Number 7. Age (In yrs. last birthday) Days Months 1 □ M 2X F I£aï∀ 578-24-3314 87 Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10a State 10b. County 1 □Yes 2 No Bethesda Montgomery Marvland 10e. Street and Number 10g. Citizen of What Country? 10f. Zip Code 5610 Madison Street 20817 United States 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11 Marital Status Black White etc. 1 ☐ Never Married 2 ☐ Married 1 □Yes 2 XNo White Specify: Specify: 3 Widowed 4 □ Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) College (1-4or 5+) Homemaker own home 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Lucia Orlando Giustino DiCamillo 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 4502 Greenwood Road Beltsville, Maryland 20705 Camillo DiCamillo, Jr. 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State Mt. Olivet Cemetery 1/2/2010 Washington, DC 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licenses Donald V. Borgwardt Funeral Home, PA 4400 Powder Mĭll Road Beltsville, Maryland 20705 02 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Urinary Bladder Cancer disease or condition resulting in death) Due to (or as a consequence of): Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Due to (or as a consequence of): IF FEMALE: 23c. If yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant Live birth 2 Fetal death 3 Ectopic pregnancy

Physician /Medical Examiner

be executed

Division of Vital Records, P.O. Box 68760.

Physician

/Medical

Examiner

Director

Funeral

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Completed

Be

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Funeral

Director

show

28a-f

23a or

death items ;

72 hours after ori

Baltimore, Maryland 21215-0036

traumatic event, the Medical Examiner must be notified at

"natural"

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and Mental Hygicis marked other

permit. Pages 1 and 2 s
Department of Health ar
Important: If item 27 is
any injury or other trau

Examiner Physician/Medical þ Be Completed

Certification: To

Medical

29b. Signature and title of certifie

attending physician a for use as the burialsigned by the a been si should I certificate has b irector, page 2 sl director, After thi funeral within 24 hours after death.

To the Funeral Director: A completely filled in by the fu

1 ☐ Yes 2 X No 9 ☐ Unknown	4 ☐ Pregnant at time of death 5 ☐ Other (specify)	Month Day fear
Part II. Other significant condition	s contributing to death but not resulting in the underlying cause given in Part I. 23e.	Did tobacco use contribute to the cause of death?
Alzheimer's Dise	ase	1 ☐ Yes 2X No 3 ☐ Probably 4 ☐ Unknown
		Was an autopsy findings available prior to completion of cause of death? Yes 2X No 1 □ Yes 2X No
25. Was case referred to medical	26. Place of Death (Check of	only one)
examiner? 1 ☐ Yes 2 X No	Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 🔀 Nursing Home 5 ☐	Residence 6 Other (Specify)
27. Manner of Death 1 ☑ Natural 5 ☐ Pending 2 ☐ Accident investigal	28a. Date of Injury (Month, Day, Year)	cribe how injury occurred
3	ad 28e. Place of Injury - At nome, farm, street, factory, office 28f. Locat	tion (Street and Number or Rural Route Number, or Town, State)
	Physician: To the best of my knowledge, death occurred at the time, date and place, and due to taminer: On the basis of examination and/or investigation, in my opinion, death occurred at the and manner stated.	

29c. License number

D43237

29d. Date signed (Month, Day, Year)

December 22, 2009



or Attending Physician;

Hospital

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

M.D. 14201 Laurel Park Drive, #102 Laurel, Maryland 20707 Paul Armstrong,

State Registrar

31. Date filed (Month, Day, Year) DEC 23



Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registra Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Anna Marion de Nobel 2009 December 19 9:24 a Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death Washington Adventist Hospital Takoma Park Mon toomerv If Under 1 Year If Under 24 Hrs. 5. Social Security Number 6. Sex . Age (In yrs. last birthday) 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** 297-24-7053 1 □ M 2 🛛 79 Hours Nov. 9, 1930 Pennsylvania Director Usual Residence of Decedent 23a or 28a-f shov permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-1 show 10b. County 10a. State 10c. City, Town or Location 10d. Inside City Limits injury or other traumatic event, the Medical Examiner must be notified at Director 1 Yes 25 No Silver Spring Maryland Montgomery 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 20906 USA 12808 Jingle Lane 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14. Race - American Indian 11. Marital Status Armed Forces <u>À</u> 1 Never Married 2 K Married 1 Yes 2 No Baltimore, Maryland 21215-0036 Specify: White 1 Yes 2 No Specify: 3 Widowed 4 Divorced Completed Year or Dates 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) 5+ Teacher Education Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) 2 Joseph Szabo Anna Solvay 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Richard Wallace de Nobel/Husband 12808 Jingle Lane, Silver Spring, MD 20906 Date 23 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State 1 Burial 2 To Cremation 3 Removal from State cemetery crematory or other place Metropolitan Crematory **20**09 Alexandria, Virginia 4 Donation 5 Other (Specify) 21. Signature of Funeral Service Licensee 22. Name and Address of Facility any Francis J. Collins Funeral Home Inc. 500 University BIVd. W., Silver Spring, MD 20901 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest Approximate Interval Between Onset and Death shock, or heart failure. List only one cause on each line Immediate Cause (Final Physician/ disease or condition resulting in death) Medical Due to (or as a consequence of) Examiner Clev Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Due to (or as a consequence of) Exami Hospital or Attending Physician: The law requires that the death certificate be executed Cause (Disease or linjury that initiated events resulting in death) Last Due to (or as a consequence of): -burial physician s the burial Physician/Medical Records, P.O. Box 68760 attending p IF FEMALE: yes, outcome of pregnancy 23b. Was decedent pregnant 23d. Date of delivery Ectopic pregnancy in the past 12 months?

1 Yes 2 No
9 Unknown Month Year Dav Pregnant at time of death Other (specify) 9 Unknown s been signed by the should be detached Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 \(\sum \) Yes \(2 \sum \) No 24a, Was an Was an autopsy performed? cate has page 2 s this certificate 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Be 1 Inpatient 2 ER/Outpatient 3 DOA
Date of injury (Month, Day, Year) 28b. Time of injury 28c. Other: 1 Tyes ပ 4 Nursing Home 5 Residence 6 Other (Specify) 27. Manner of De ti Certificate: 28c. Injury at work? 1 ☐ Yes 28d. Describe how injury occurred 1 X Natural 5 Pending 2 🗌 No Investigation Accident 6 Could not be Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) Homicide 28f. Location (Street and Number or Rural Route Number, determined

Division of Vital within 24 hours after death.

To the Funeral Director: After this completed filled in by the funeral c the

State

DHMH 17 Rev 7/2009

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Medical

29a. Certifier

29b. Signatu

(Check only one

31. Date filed (Month, Day, Year)

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Registrar's Sign

Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

City or Town, State)

29d. Date signed (Month, Day, Year)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

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S	Sta	te	of	Mar	yland	I / De	partmer	nt of	Health	and	Mei	ntal	Hyg	ier

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		1- For State Registrar	Cer	rtificate of	Death	7.5	Reg. No.	_ 0 0 5	7 1201.			
Physici ical Exam		1. Decedent's Name (First, Middle, La THOMAS HOW	Year 3	3. Time of Death 1117 hrs								
		4a. Facility Name (if not institution, g	ive street and number)		4b. City, Town, or Location			nty of Death				
		Chester River Hospital C			Chestertown		Kent					
Funeral			Sex 7. Age (In yrs. I		If Under 1 Year If Under Months Days Hours	1.0	Birth (MM/DD/YY	Foreign				
Director			XM 2 F 7	8 Yrs		Mar	13 193	1 Coun	ntry) Delawar			
any		Usual Residence of Decedent 10a. State 10b. County	I10c City	, Town or Locat	ion	_			10d, Inside City Limits			
- A4		DE Kent		myrna	NII				1 Yes 2 No			
ryland a-f sh it ooc	cto	10e, Street and Number			10f. Zip Code	_	10a. Citizen of					
or 28	Director	2080 Big Woo	ds Rd.		19977		U.S.		'			
with 1 18 23a	Ē	11. Marital Status	12. Was Decedent Ever in U.	.S. 13. Wa	s Decedent of Hispanic Orig	gin? (Specify Yes or			en Indian, Black,			
r iten	Funeral	1 Never Married 2 X Marrie	Armed Forces?	If Y	es, specify Cuban, Mexican	, Puerto Rican, etc.)	W	hite, etc.				
after o	by F	3 Widowed 4 Divorce	ed If Yes, Give Year Korea	1	Yes 2 X No specify:		Specif	y: Whi	te			
nours Datur	pa	15. Decedent's Education (Specify			t's Usual Occupation (Give ost of working life, DO NOT		16b. Kind of	Business/Ind	dustry			
imore, MD 21215-0036 Pages I and 2 should be filed within 72 hours after death with the Maryland ment of Health and Mental Hygiene tane: If firem 51 is marked other than "oatural", or items 23a or 28a-f show or other traumatic event, the Medical Examiner must be sotified at once.	Completed	Elementary/Secondary (0-12)	College (1-4 or 5+)		e Trooper	400 10111047	Stat	e of	Delaware			
with giene giene	Ho	17. Father's Name (First, Middle, Las	st)			's Name (First, Middle			Belaware			
e filed al Hy ced of	Be C	Roy Everett	.,			lith Cook		ne)				
2121 2121 ould be fi Mental marked c event,	آه ا	19a. Informant's Name/Relationship	(Type, Print)	19b. Mailing	Address (Street and Num			own, State, 2	Zip Code)			
MD 12 shoth and the an		Lois Everett	(wife)	2080) Big Woods	Rd. Sm	yrna,	DE. 1	9977			
Ore, MD es 1 and 2 sho of Health and If item 27 is		20a. Method of Disposition 1 X Burial 2 Cremation 3		Place of Dispos	ition (Name of cemetery,	Date	20c. Locatio	on - City or To	own, State			
Pages ent of int: I		4 Donation 5 Other Special	Ho	ckess	n Friends	12/21/0	9 Hoc	kessi	n, DE.			
Baltimore, MD 21215-0036 permit. Pages 1 and 2 should be filed within 7 Department of Health and Mental Hygier Important: If titem 27 is marked other than iojury or other traumatic event, the Medica		21 Signature of Funeral Service Lice		22. N	lame and Address of Facility	y Direc	+	~ d				
		700	M005	10 29	9 S. Main S	t. Smyrn	a. DE.	1997	7			
Physician /Medical		23a. Part I. Enter the disease, or confailure. List only one cause on		. Do not enter t	ne mode of dying, such as c	ardiac or respiratory	arrest, shock, or	heart	Approximate Interval Between Onset and			
xaminer		Immediate Cause (Final disease or condition resulting in death)	Atherosclerotic Cardiov		ease				Death			
			Due to (or as a consequence o	or):								
	ner	Sequentially list conditions, if any, leading to immediate	Due to (or as a consequence o	of):								
	Examiner	Cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of):										
760, icate be executed physician and the burial - transit	E	events resulting in death) Last	d.									
e exection and rial - t	/Medical	UNPENDED	AMENDED	·								
Box 68760, e death certificate be the attending physic ed for use as the bur	/Me	IF FEMALE: 23b. Was decedent pregnant in the	23c. If yes, outcome of preg	inancy			23d. Date	of delivery				
68 certifi nding ise as	ian	past 12 months?	1 Live birth 4 Pregnant at time of de	ath	tal death 3 Ectopic	c pregnancy	Month	n Da	y Year			
30X death ne atte I for u	Physiciar	1 Yes 2 No 9 Unknow		eath 5 Ot	her (Specify)		· ·					
at the	'Ph	Part II. Other significant conditions	contributing to death but not re	esulting in the u	ınderlying cause given in Pa	art I. 23e. Die	tobacco use co	ntribute to th	e cause of death?			
tal Records, P.O. Box 68 cian: The law requires that the death certificate has been signed by the attending ector, page 2 should be detached for use as	d by	diabetes				1 🗆 `	Yes 2 No	3 Probal	bly 4 🗸 Unknown			
Vital Records, ysician: The law requir his certificate has been a director, page 2 should	Completed					24a. Wa	as an 24t topsy		psy findings available mpletion of cause of			
ecc he lav ate har	шо					ре	rformed? s 2 ✔ No	death?	2 No			
an: T entification, p	C	25. Was case referred to medical			26.Place of Death							
Vit; hysici this co	0	examiner? 1 Yes 2 No	Hospital: 1 Inpatient 2	ER/Outpatient	3 DOA Other	Nursing Home 5	Residence 6	6 Other:				
ing P After funera	n: T	27. Manner of Death 1 ✓ Natural 5 □ Danding	28a. Date of Injury (Month, Day,Year)	28b. Time of I			e how injury occ	urred				
SiOr tteod death ctor: y the	atic	2 Accident Pending	ation		1 Yes 2							
Division of Vital Records, plat or Atteoding Physician: The law requir ours after death ours after cert After this certificate has been si filled in by the funeral director, page 2 should b	Certification:	3 Suicide 6 Could no determin	ot be	ome, farm, stree	et, factory, office building, et		n (Street and Nur n, State)	nber or Rura	Route Number, City			
Ospita ospita hours uoeral		29a Certifier	(oposity)									
Division of Vital Records, P.O. Box 68760, note the despital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial - trans	edical	(Check only Certifying Physi	cian: To the best of my knowled er:On the basis of examination a									
To To com	Med	29b. Signature and title of certifier	and manner stated.		29c. License number			igned (Monti				
5		10 0 .11	No 1 m	, >	O.C.M.E.	OCME		er 17, 200				
		30. Name and address of person who	completed cause of death (Item	23a)	0,	OUNE						
د در		Theodore M. King, Jr., M	•	Examiner	111 Penn Street, Ba	Itimore, MD 212	01					
	tate	31. Date filed (Month, Day, Year)	32. Registrar's Signatu	net foa	Mar							
Regis	strar	DEC 2 8 2	2009 Jenewa	B. 1900								

DHMH 17 Rev 7/2009

09-10091 Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. Rodell Ford, Jr. State of Maryland / Department of Health and Mental Hygiene 2009 4281 1-For State AMEND#16a Per FH. RegistraAACO HFALTH DEPT 1/5/2010 CMH Certificate of Death Physician/ 2. Date of Death Month Medical Examiner Rodell Ford Jr. December 26, 2009 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death c. County of Death 32 Twin Circle Way Landsdowne **Baltimore County** 5. Social Security Number 7. Age (In yrs. last birthday) If Under 24Hrs. 8. Date of Birth(MM/DD/YYYY) 9. Birthplace (State or If Under 1 Year **Funeral** Hours Director Months Days co**Ma**ry1and 220-84-3767 41 July 4 1968 1X M 2 F Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits Maryland Anne Arundel Annapolis 1 Yes 2 No other than "natural", or items 23a or 28a-f show the Medical Examiner must be notified at once. hours after death with the Maryland Director 10e. Street and Number 10g. Citizen of What Country? 10f. Zip Code 38 Pleasant St. 21403 USA Funeral 11 Marital Status 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-14. Race - American Indian, Black, Armed Forces? If Yes, specify Cuban, Mexican, Puerto Rican, etc.) White etc. 1 Never Married 2 X Married 2 X No Yes If Yes, Give Year Black 4 Divorced Yes 2X No specify: Specify: \$ 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b Kind of Business/Industry Completed timore, MD 21215-0036

1. Pages 1 and 2 should be filed within 72 hou ment of Health and Mental Hygiene.
Trant: If item 27 is marked other than "nat or other traumatic event, the Medical Exa Elementary/Secondary (0-12) College (1-4 or 5+) Maintenance 12th Heritage Harbour 0 Custodiar 17. Father's Name (First, Middle, Last) 18.Mother's Name (First, Middle, Maiden Surname) Rodell Ford Sr. Deborah Johnson 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Rico Queen(Brother) 904 E Royal St. Annapolis, Md. 21401 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 1 X Burial 2 Cremation 3 Removal from State Department of Important: I Memorial Park 1-4-10 Annapolis, Md. Donation 5 Other Specify: ²₩₩™[®] aR**etese** f& lib Sons Mortuary, F 821 West St. Annapolis, Md. 21. Signature of Funeral Service Licensee + arm 23a. Part I. Ent., the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart Physician Approximate Interval failure. List only one cause on each line. Between Onset and /Medical a Gunshot wound of head Immediate Cause (Final disease Examiner or condition resulting in death) Due to (or as a consequence of): Sequentially list conditions, Due to (or as a consequence of): Examiner if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated Due to (or as a consequence of): events resulting in death) Last the attending physician and ed for use as the burial - transi sician/Medical UNPENDED AMENDED 23a,27,28af-,per ME g899 1/11/10 TT 23c. If yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant in the Live birth Day 3 Ectopic pregnancy Month Fetal death past 12 months? 2 Pregnant at time of death 5 Other (Specify) 1 Yes 2 No 9 Unknown q [Unknown Phy Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ۾ Yes 2 No 3 Probably 4 ✔ Unknown Completed 24a Was an 24b. Were autopsy findings available autopsy page 2 performed? death? ✓ Yes 2 No 1 🗸 Yes

Division of Vital Records, P.O. Box 68760, certificate has this After 24 hours after death. To the Funeral Director:

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filled

prior to completion of cause of No 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Hospital: 1 Other Nursing Home 5 Residence 6 Other: Scene DOA Inpatient 2 ER/Outpatient 3 1 Yes 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of Injury 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural subject shot self 1 Yes 2 X No 5 Pending Fd 6:14 am 12/26/09 Accident 28e. Place of Injury - At home, farm, street, factory, office building, etc 28e. Place of Injury - At home, farm, street, factory, office building, etc.

(Specify) Multi-family apartment building or Town, State) 22 Twin Circle Way

Lansdowne , MD 3 X Suicide Homicide

O.C.M.E.

0622 hrs

Year

December 27, 2009

29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)

29b. Signature and title of certifie 29c. License number 29d. Date signed (Month, Day, Year)

Dou 30. Name and address of person who completed cause of death (Item 23a)

Carol Allan, MD Assistant Medical Examiner 111 Penn Street, Baltimore, MD 21201

31. Date filed (Month, Day Year State Registrar

OCME

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death **Physician** Dorothy Lorraine Feaganes December /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner ENIER -IVISTA 5. Social Security Number If Under 1 Year | If Under 24 Hrs. 7. Age (In yrs. last birthday, Birthplace (State or Foreign Country) **Funeral** Date of Birth (Month, Day. 1 □ M 2 🔽 F Months Days Hours Min. 219-34-8820 Director 83 June 28, 1926 Washington D.C. Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 28a-f show item 27 Is marked other than "natural", or Items 23a or 28a-f show other traumatic event, the "natical Examinar must be not the date. Director 1 ☐ Yes 2**X**☐ No Maryland Charles Indian Head 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 3700 Chapmans Lane 20640 U.S.A. Funeral 12. Was Decedent Ever in U.S. Armed Forces?

1 Yes 2 No Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 11. Marital Status 1 ☐ Never Married 2 ☐ Married Maryland 21215-0036 Yes. Give 1 □Yes 2 No Specify. \$ Specify: White 3 ☐ Widowed 4 ☒ Divorced Year or Dates: Completed 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) marked other than Elementary/Secondary (0-12) College (1-4or 5+) 12 Credit Assistant Oil Company 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) John William Crampton Cora Estelle Pennifield 19a. Informant's Name/Relationship (Type. Print) permit. Pages 1 and 2 she Department of Health and Important: If item 27 Is many injury or other traum 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Mollie D. Valentine Daughter 3700 Chapmans Lane, Indian Head, Md. 20640 Baltimore, 20b. Place of Disposition (Name of cemetery, crematory or other place) Dec. 23, Date 2009 20a. Method of Disposition 20c. Location - City or Town, State 1 ☐ Burial 2 【XCremation 3 ☐ Removal from State Metropolitan Funeral Service 4 ☐ Donation 5 ☐ Other (Specify) Alexandria, Virginia 22. Name and Address of Facility
Williams Funeral Home, P.A. 21. Signature of Funeral Service License ₩**9**0668 4270 Hawthorne Rd., Indian Head, Md. 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiagor respiratory arrest, shock, or heart fathere. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician disease or condition resulting in death) /Medical Due to (or as a consequence of Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examine Due to for as a consecu The law requires that the death certificate be executed and -trans the attending physician a ned for use as the burial-Due to (or as a consequence Box 68760. Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant in the past 12 months? 23d. Date of delivery 3 Ectopic pregnancy Month 4 Pregnant at time of death 5 ☐ Other (specify) signed by the a 1 ☐ Yes 2 No 9 ☐ Unknown 0 9 Unknown ۵. Part II. Other significant conditions contrib sulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Records, þ Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an After this certificate has funeral director, page 2: autopsy perform 1 □Yes 2 No of Vital Hospital or Attending Physician: 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Tes 1 Inpatient 2 ER/Outpatient 3 DOA Certification: To 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Division Natural 5 Pending To the Hospital or Attendir within 24 hours after death. To the Funeral Director: A completely filled in by the ft 2 Accident investigation 1 ☐ Yes 2 ☐ No 6 Could not be determined 3 Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical (Check only one)

State

Registrar

29b. Signature and title

Date filed (Month, Day, Year)

of certifie

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

enna

Medical

32. Registrar's Signature

29c. License number

29d. Date signed (Month, Day, Year)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Registrar . Decedent's Name (First, Middle, Last) 2. Date of Death December 24, 2009 Physician/ 6:25A Ermon Nelson Foster Medical 4a. Facility Name (if not institution, give street and number) 4c. County of Death Examiner 4b. City, Town, or Location of Death Kent Chester River Manor Chestertown Social Security Number If Under 1 Year If Under 24 Hrs. **Funeral** 7. Age (In yrs. last birthday) 8. Date of Birth 9. Birthplace (State or Foreign 1 X M 2 🗆 F Hours (Month, Day, Year) 5/9/1918 **Director** 226-07-6243 91 VA Usual Residence of Decedent ms 23a or 28a-f shov must be notified at Page 1 and 2 should be filed within 72 hours after death with the Maryland nent of Health and Mental Hygiene.
ant: If item 27 is marked other than "natural", or items 23a or 28a-f shor 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director 1 ☐ Yes 2 No Chestertown MDKent 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral IISA 25741 Pearce Way 21620 "natural", or items edical Examiner mu Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 12. Was Decedent Ever in U.S. 14. Race - American Indian, Armed Force þ 1 Never Married 2 Married ☐ Yes 2 🏋 No Yes, Give Baltimore, Maryland 21215-0036 Specify: White 1 ☐ Yes 2 X No Specify: Completed 3 X Widowed 4 Divorced Year or Dates nt of Health and Mental Hygiene.

If item 27 is marked other than "nature or other traumatic event, the Medical. 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) 12 College (1-4 or 5+) Registrar & Professor Education Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) မ Capas Weldon Foster Amy Ludwig 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 411 Baxter Rd. Sudlersville, Bonnie Howell/Daughter MD 21668 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Burial 2 Cremation 3 Removal from State Department Important: It any injury or St. Paul's 12/31/09 Chestertown, MD 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licenses 22. Name and Address of Facility
Fellows, Helfenbein & Newnam Funeral Home 130 Speer Rd. Chestertown, MD 21620 Approximate Interval Between Onset and Death 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final Physician Metastatic disease or condition resulting in death) melanoma Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Fitter Lindsrying Cause (Disease or linjury Examine Due to (or as a consequence of) that the death certificate be executed To the Funeral Director: After this certificate has been signed by the attending physician and completed filled in by the funeral director, page 2 should be detached for use as the burial-tran that initiated events resulting in death) Last Due to (or as a consequence of) Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?

1 Yes 2 No Month Day Year Pregnant at time of death 5 Other (specify) 9 Unknown q Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Completed 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an 1 Yes 2 No Be 25. Was case referred to medical 26. Place of Death (Check only one) examiner? မ 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) 27. Manner of Death Date of injury (Month, Day, Year) Certificate: 28b. Time of 28c. Injury at work? 1 ☐ Yes 2 ☐ No 28d. Describe how injury occurred Natural 5 Pending Accident Investigation 6 Could not be Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) Homicide determined Medical

To the Hospital or Attending Physician: The law requires t within 24 hours after death.

To the Funeral Director: After this certificate has been sign

State Registrar 29a, Certifier (Check only one)

29b. Signature and title of certifier

of person who con

30. Name and address

31. Date filed (Month, Day

12

MO

pleted cause of death (Item 23a) (Type, Print)

Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

D0051735

29d. Date signed (Month, Day, Year)

29c. License number

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2, Date of Death 3. Time of Death Physician/ 2009 Evelvn M. Ferrin December 1:25 Medical р 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death Chester River Hospital Center Kent Chestertown **Funeral** 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign Days 1 □ M 2 🖾 F Hours 6 13 / 19 12 Director 504-38-0171 MN Usual Residence of Decedent ral", or items 23a or 28a-f shov Examiner must be notified at 10b. County 10a, State 10c. City, Town or Location 10d. Inside City Limits Director 1 Yes 2 No MD Kent Chestertown 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 203 Leeds Ct. 21620 12. Was Decedent Ever in U.S. Armed Forces? 11. Marital Status 13. Was Decedent of Hispanic Origin? (Specify Yes or No-14 Race - American Indian If Yes, specify Cuban, Mexican, Puerto Rican, etc." Black, White, etc. "natural", or 1 Never Married 2 Married Completed by 1 Yes 2 X No 1 Yes 2 X No Specify: Specify: 3 X Widowed 4 Divorced White Year or Dates other traumatic event, the Medical 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) 2 should be filed within 72 l h and Mental Hygiene. 7 is marked other than "r Elementary/Seconday (0-12) College (1-4 or 5+) Own Home Homemaker Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) မ John Thorvaldson Marie Ostlie 19a. Informant's Name/Relationship (Type, Print) and 2 shou Health and tem 27 is n 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 203 Leeds Ct. Chestertown, MD 21620 Mary Dewey/Daughter permit. Page 1 and 2 Department of Health Important: If item 2 any injury or other 1 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 ☐ Burial 2 X Cremation 3 ☐ Removal from State 4 Donation 5 Other (Specify) 12/23/09 Chesapeake Cremation Stevensville, MD 21. Signature of Juneral Service Licenses 22. Name and Address of Facility Fellows, Helfenbein & Newnam Funeral Home 130 Speer Rd. Chestertown, MD 21620 23a, Part 1. Enter the disease, or complical ns that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between shock, or heart failure. List only one Onset and Death Immediate Cause (Final eretrovo-cello Physician/ disease or condition resulting in death) Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury that initiated as or injury Due to (or as a consequence of): death certificate be executed attending physician and for use as the burial-transi that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical 23c. If yes, outcome of pregnancy 1 ☐ Live Birth 2 ☐ Fetal death 4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy 5 Other (specify) ____ in the past 12 months? 1 Yes 2 No Month Day Year Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 Yes 2 1 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy 2 🗌 No 1 🗌 Yes 2 🔼 1 Yes 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Other: 1 Yes 2 1 No ည 1 Dinpatient 2 ☐ ER/Outpatient 3 ☐ DOA 4 Nursing Home 5 Residence 6 Other (Specify) 27. Manne of Death 28a. Date of injury (Month, Day, Year) Certificate: 28h Time of 28c. Injury at 28d. Describe how injury occurred 1 Natural 2 Accider 5 \square Pending work 1 Tes 2 No Accident Investigation Could not be 3 Suicide 4 Homicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, determined City or Town, State)

Box 68760 a Hospital or Attending Physician: The law requires that the c 24 hours after death.
24 hours after death.
2 Funeral Directors. After this certificate has been signed by the leted filled in by the funeral director, page 2 should be detached. P.O. Records. Division of Vital npleted within 2

Baltimore, Maryland 21215-0036

Registrar

State

Medical

29a. Certifier

only one)

29b. Signature and title of certifier

31. Date filed (Month, Day, Year)

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Washington

32. Registrar's Signature

ertifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Clos for took

2 | Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

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			Registrar 1. Decedent's Name (First, Middle, Las	st)	00	Timeate or	Deali	2. Date of Dea	Reg. No. ZUU	3. Time of Death
	Physicia /Medic		Nettie Christi	ne Grinder				Decembe	Day Year	9 3:45P M
	Examin		4a Facility Name (If not institution, give			4b. City, Town, o	or Location of Deat		4c. County of Dea	ath = 5
أنمير					TER	L-A	PLATA	1.00.	CHAR	LES
	Funeral Director		5. Social Security Number 6. S 224–36–2594	ex	. last birthday) Yrs.	If Under 1 Year Months Days	If Under 24 Hrs Hours Min.	(Month, Day		rthplace (State or Foreign country)
			Usual Residence of Decedent	13				March 2	2,1930 V.	irginia
	show	_	10a. State 10b. County	10c. C	ity, Town or Lo	cation				10d. Inside City Limits
	he Ma	ecto	Maryland Charle	s I	ndian H				40.00	1 □XYes 2 □ No
	with t	ä	13 Fairmont Place			10f. Zip Code	20640		10g. Citizen of What C	ountry?
	within 72 hours after death with the Maryland iene. than "natural", or Items 23a or 28a-f show he Madical Examination at the motified at	Funeral Director	11. Marital Status	12. Was Decedent Ever in L	J.S. 13.	Was Decedent of I If Yes, specify Cub		Specify Yes or No-		
õ	after or Ite	/ Fu	1 ☐ Never Married 2 ☐ Married	Armed Forces? 1 ∐Yes 2 MX No If Yes, Give		if Yes, specify Cub 1 ∐Yes 2 1∑ 1 No		to Rican, etc.)	016	
3-003b	ural",	d by	3	Year or Dates:		••				White
2	in 72 l	Completed	15. Decedent's Ed (Specify only highest gra	de completed)	16a. Dece (Give life.	dent's Usual Occup kind of work done DO NOT use retire	pation during most of wo d)	rking	16b. Kind of Business	s/Industry
7	filed withir Il Hygiene. other than ent, the m	mo;	Elementary/Secondary (0-12)	College (1-4or 5+)		ol Bus Dr			Board of 1	Education
and		Be C	17. Father's Name (First, Middle, Last)					me (First, Middle,	Maiden Surname)	
y a	should be nd Ments marked imatic ev	2	Bennie Campbell				L	Estell Ro		
Ma	12sh thand 7 Ism traum		19a. Informant's Name/Relationship (er, City or Town, State, , Indian He	Zip Code) 20640
<u>မ</u>	1 and Healt tem 2		Glenda Buck 20a. Method of Disposition	Daughter 206.	Place of Dispo	osition (Name of	;	Date Date	20c. Location - City o	
аппто	permit. Pages 1 and 2 should by Department of Health and Menta Important: If Item 27 is marked any Injury or other traumatic e once.		Burial 2 ☐ Cremation 3 ☐ 4 ☐ Donation 5 ☐ Other (Specify	Removal from State	cemetery, cie rinity	osition (Name of matory or other pla Memorial	ce) Jan 2,	2010	Waldorf, N	Marvland
= =	permit. Departm Importa any Inju		21. Signature of Funeral Service Lic		2:	Name and Addre	ess of Facility	II D		7
מ	9 9 E 2 9	1 2	23a. Part 1. Enter the disease, or com	MO		Williams				3. 20640
			shock, or hear tarture. List only	olications that caused the dea one cause on each line.	ith. Do not en	ter the mode of dyi	ng, such as cardia	c or respiratory an	rest,	Approximate Interval Between Onset and Death
-	Physician /Medical		Immediate Cause (Final disease or condition resulting in death)	a. <u>Sepsis</u>						73 hours
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	7 +	ner	Sequentially list conditions, if any, leading to immediate Cause (Disease or injury	b Due to (or as a conse	quence of):					
	ecuted and transi	Examiner	Cause (Disease or injury that initiated events resulting in death) Last	С						(1)
0/00,	ficate be executed physician and s the buriat-transit	E E	resulting in death) East	Due to (or as a conse	quence of):					
	ficate phys sthe	edical		.d						
X O O	anding use a	υ/M	IF FEMALE: 23b. Was decedent pregnant	23c. If yes, outcome of pregr		7			23d. Date of d	elivery
D	e death	sicia	in the past 12 months? 1 ☐ Yes 2 🔊 No	1 ☐ Live birth 2 ☐ Fet 4 ☐ Pregnant at time of 9 ☐ Unknown		☐ Ectopic pregnand ☐ Other <i>(specify)</i> _	cy 		Month	Day Year
r L	d by the etach	Physician/M	9 Unknowh		aultina in the co	adadidas socias st	one in Post I	220 Did to	phono une contributo	to the cause of death?
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N Ea	lan: T	e e	25. Was case referred to medical				26. Place of De	1 ☐ Yes ath (Check only or		es 2 No
>	hysic his ce I direc	To B	examiner? 1 ☐ Yes 2 No	Hospital: Inpatient 2] ER/Outpatie	nt 3 DOA Oth	oor:		dence 6 ☐ Other (Sp	pecify)
S	Ing P	ou:	27. Manner of Death 1 Natural 5 □ Pending	28a. Date of Injury (Month, Day, Year)	28b. Time o Injury	Wor	rk?	28d. Describe h	now injury occurred	
VISION OF	death death ctor: , the f	icat	2 Accident investigation 3 Suicide 6 Could not be		nome farm str		Yes 2 No	28f Location (S	Street and Number or F	Bural Bouta Number
3	after Direction by	Certification: To	4 ☐ Homicide determined	building, etc. (Spec	ify)	oot, tuotory, omoc		City or Tow	in, State)	narai noute Naimber,
	To the Hospital or Attending Physician: The law requires that the death certific within 24 hours after death. within 24 hours after death. to the Funeral Director: After this certificate has been signed by the attending is completely filled in by the funeral director, page 2 should be detached for use as	Medical (ysician: To the best of my kn niner: On the basis of examin and manner stated.						
	To th To th comp	Me	29b. Signature and title of certifier			29c. Licens			29d. Date signed (Mor	
			1 3 2		ms	D-3	3426		12/22	109
6	20		30. Name and address of person who			•	. 0		,,	
K	100		JENKINSJR, B. LARI	KY, MD, III LA	GRANGI	AVE, L	A PLATA,	MD 2064	46	

DHMH 17 Rev 1/2001

State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Month Day Year MERRILL М GRAY Medical **Examiner** 4a. Facility Name (if not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Death PENINSULA REGIONAL MEDICAL CENTER SALISBURY WICOMICO 5. Social Security Number If Under 1 Year If Under 24 Hrs. 7. Age (In yrs. last birthday) 8. Date of Birth Birthplace (State or Foreign Country)
 DELAWARE **Funeral** 1 X M 2 □ F Days (Month, Day, SEPT 1 Months Hours Min. Year Director 221-18-5831 80 Usual Residence of Decedent or than "natural", or items 23a or 28a-f show the Medical Examiner must be notified at 10b. County 10a. State within 72 hours after death with the Maryland 10c. City, Town or Location 10d. Inside City Limits Director 1 ☐ Yes 2 X No DELAWARE SUSSEX FRANKFORD 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 32328 POWELL FARM ROAD 19945 USA Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Armed Forces? Black, White, etc <u>۾</u> 1 Never Married 2 Married Maryland 21215-0036 If Yes Give 1 ☐ Yes 2 X No Specify 3 Widowed 4 Divorced Specify: WHITE Completed Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) and Mental Hygiene. is marked other than Elementary/Seconday (0-12) College (1-4 or 5+) CARPENTER CONSTRUCTION Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ဂ JAMES Μ. GRAY HATTIE MURRAY and 2 should b Health and Mer tem 27 is mark 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) FLORENCE M. GRAY/WIFE 32328 POWELL FARM ROAD, FRANKFORD, DE. 19945 permit. Page 1 and 2 Department of Health Important: If item 2: any injury or other t 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 Burial 2 Cremation 3 Removal from State GEORGE'S CEMETERY 4 Donation 5 Other (Specify) 12/22/09 CLARKSVILLE, DELAWARE 21. Signature of Puperal Service Lick 22. Name and Address of Facility HASTINGS FUNERAL HOME. SELBYVILLE, Part 1. Enter the disease, or complications that caused the peath. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final Onset and Death Physician/ disease or condition Medical resulting in death) Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Examine Due to (or as a consequence of) that the death certificate be executed the burial-transi that initiated events resulting in death) Last Due to (or as a consequence of) physician Physician/Medical for use as IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?

1 Yes 2 No Pregnant at time of death 5 Other (specify) Month Day Year 9 Unknown detached 9 Unknown à s been signed to should be det Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I. Completed by 23e. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an Hospital or Attending Physician: The law page 2 s certificate has autopsy performed? Yes 2 No __ Yes 25. Was case referred to medical funeral director, Be 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) ပ္ 1 Yes 2 No 1 Ninpatient 2 ER/Outpatient 3 DOA this 27. Manner of Death Certificate: 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at work? 28d. Describe how injury occurred 1 Natural 5 Pending 1 Yes 2 No Accident Investigation s after death completed filled in by the 6 Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Division of Vital 24 hours To the within 2

Baltimore,

Box 68760

P.O.

Records,

State Registrar

29a. Certifier

only one)

ennis

29b. Signature and title of certifier

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

DHMH 17 Rev 7/2009

P. R. M.C

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated

Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated

100 E. Carroll St.

29d. Date signed (Month, Day, Year)

Salis bury mD21801

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene 2009 428 9

State Registrar Certificate of Death

1. Decedent's Name (First, Middle, Last)

Toggaph Anthony Crimal dia 3. Time of Death Month Day Year 3. 200 mm Month Day Mon

)	Physic Me Exan	dical
	uner	
land	show	tor

permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Baltimore, Maryland 21215-0036

Physician/
Medical
Examiner

Division of Vital Records, P.O. Box 68760

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completed filled in by the funeral director, page 2 should be detached for use as the burial-transit

al	Joseph Anthony (Grimaldi						Decem	ber	18,	2009	3:20 I	р м	
er	4a. Facility Name (if not institution, give	e street and number)	4	b. City, Town, or	Location	of Death		4	c. County	of Death				
	Holy Cross Hosp				Silver	Sprin	ng]]	Montg	omer	У		
	5. Social Security Number 6. S 579–28–4820	ex M 2 □ F	e (In yrs. last birth 83		If Under 1 Year Months Days	If Under Hours	24 Hrs. Min.	8. Date of Bi Jan. 1	th 2 Year, 2	1926		nplace (State or ntry) hingtor		
	Usual Residence of Decedent													
tor	10a. State 10b. County		10c. City, Town	or Locat	ion							10d. Inside Cit	y Limits	
je.	Maryland Montgo	omery	Silve	er St	oring							1 🗆 Yes	2 🔀 No	
ā	10e. Street and Number			1	10f. Zip Code				10a (Citizen of V	What Cou	intry?		
To Be Completed by Funeral Director	2725 Weller Roa	ad			2090)6			109.	USA				
Fu	11. Marital Status	12. Was Decedent I Armed Forces?	Ever in U.S.	13. Wa	s Decedent of Hi es, specify Cuba	ispanic Ori	igin? (Spe	cify Yes or No-				American Indian, White, etc.		
by	1 Never Married 2 🔀 Married	1 🔀 Yes 2 🗆	No					inouri, oto.,						
eq	3 Widowed 4 Divorced	If Yes, Give Year or Dates.	1944-49	1 -	Yes 2 🔀 No	Specify:	·			Specify:	Whi	се		
et	15. Decedent's E		16a.	Deceden	t's Usual Occup	ation			16b.	Kind of Bu	usiness Ir	ndustry		
Ë	(Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) Teacher 17. Father's Name (First, Middle, Last) Paul Grimaldi 18. Mother's Name (First, Middle, Maiden Surname) Angelina DeLuca 18. Mother's Name (First, Middle, Maiden Surname) Angelina DeLuca 18. Mother's Name (First, Middle, Maiden Surname) 18. Mother's Name (First, Middle, Maiden Surname)										Hig	h Schoo	01	
ပိ											ion			
Be											J			
To											*)			
	19a. Informant's Name/Relationship (7	Type, Print)	19b.	Mailing	Address (Street a	and Numbe	er or Rura	I Route Numbe	er, City	or Town, S	tate, Zip	Code)		
	Josephine V. Grim	naldi/Wife	27	25 W	eller R	oad,	Silv	er Spr	ing,	MD	2090	6		
	20a. Method of Disposition		20b. Place of	Dispositi	on (Name of			Date	200	Location -	City or T	own, State		
	1 🖾 Burial 2 🗆 Cremation 3 🗀	Removal from State	cemeter	, cremat	ory or other place eaven Ce	e)		Dec. 23	,					
	4 Donation 5 Other (Special		Gace c	_				2009	Sil	ver	Spri	ng, Mar	cyland	
	21. Signature of Funeral Service Licen	see	21 _		ame and Address ncis J. Univer			Funera	ļ Ho	me I	nc.	- MD C	20001	
	00000									er s	prin			
	23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Atherosclerotic Cerebrowascular Disease Due to (or as a consequence of):											Interval Betv	veen	
												Onset and D	eath	
Jer	Sequentially list conditions, if any, leading to immediate cause Enter I Inderlying Due to (or as a consequence of):													
Ē	cause. Enter Underlying Cause (Disease or iinjury													
Exa	that initiated events resulting in death) Last	C. Due to (or as	a consequence o	f):				· · · · · · · · · · · · · · · · · · ·						
Physician/Medical Examiner	·	d												
Med	IF FEMALE													
7	IF FEMALE: 23b. Was decedent pregnant	23c. If yes, outcome	of pregnancy							23d. Dat	te of deliv	/erv		
cia	in the past 12 months? 1 ☐ Yes 2 ☐ No	1 ☐ Live Birth 4 ☐ Pregnant a	2 Fetal death	3 ∐ E	ctopic pregnanc other (specify)	y				Mo			ear	
ıysi	9 Unknown	9 🗌 Unknown			. (4 3/									
	Part II. Other significant conditions of	ontributing to death b	ut not resulting in	the und	erlying cause giv	en in Part	I.	23e, Did t	obacco	use contr	ibute to t	the cause of de	eath?	
g	Hypernatremia, Dysph													
Be Completed by	JETHOLAMA, DJOME	ganay Cirry D.	vac		. D			1 🗆	res	∠ 🖾 N0	ა ⊔ Pro	obably 4 🗆 L	ικποwn	
ble	Advanced Dementia							24a. Was		24b. V	Vere auto	opsy findings a	vailable	
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ŭ	25. Was case referred to medical					(5	11- (0)		2 X	No 1	I ∐ Yes	2 🗌 No		
B	examiner?	Hospital:			Othe	ace of Dea								
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ate:	27. Manner of Death ★★★ Natural 5 ☐ Pending	28a. Date of inju (Month, Day		me of jury	28c. Injury work		2	28d. Describe I	now inju	ary occurre	ed			
ije Les	2 Accident Investigation	n				Yes 2	No							
Ĕ	3 ☐ Suicide 6 ☐ Could not b	28e. Place of Inju	ry - At home, far	n, street,	factory, office		1				er or Rura	l Route Numbe	er,	
ပ္	2010/111104	building, etc	:. (ъресіту)					City or Tov	vn, Stat	re)				
ca	29a. Certifier 1 K Certifying Phys	sician: To the best of	mv knowledae d	eath occ	ured at the time	date and	place and	d due to the co	use(s)	and manne	er as state	ed		
Medical Certificate: To	(Check 2 Medical Exami	iner: On the basis of ease Practioner: To the	xamination and/or	investiga	tion, in my opinio	n, death od	curred at	the time, date a	and plac	ce, and due	to the ca	ause(s) and man	ner stated.	
2	only one) 3 ☐ Certifying Nurs	- ractioner: to the	A A	uye, uea	29c. License	_	anu piace	s, and due to tr		, ,				
	· R- Shy	andr	velon	3		3367		Ī		ate signed iber 18				
	30. Name and address of person who	completed cause of d	eath (Item 23a) (T	ype, Prin	t)	·		·						
	Rajan Shyamsundar,	MD 9801	Georgia Av	enue,	Silver S	pring,	, MD 2	20902						
6	31. Date filed (Month, Day, Year)		ar's Signature											
e ır	31. Date filed (Month, Day, Year) DEC 23 200		ar's Signature	back	ジ									

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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Month HOFFMAN NALD Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City. Town, or Location of Death 4c. County of Death ANNAPOLIS MEDICAL CENTER ANNS ARUNDE! 7. Age (In yrs. last birthday, 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** 1 **№** M 2 □ F Months Days Hours (Month, Day, Ye Director 215-42-2405 Ol 10 MD 11 Usual Residence of Decedent or 28a-f show notified at 10b. County 10a. State 10c, City, Town or Location 10d. Inside City Limits Director MD Oueen Annes Stevensville 1 Yes 2 X No 10e. Street and Number 10f. Zip Code ò 10g. Citizen of What Country? . Hygiene. other than "natural", or items 23a or rent, the Medical Examiner must be r Funeral 803 Kimberly Way 21666 72 hours after death Was Decedent Ever in U.S Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11 Marital Status 14. Race - American Indian Armed Forces?
1 ☐ Yes 2 ☐ No Black, White, etc. þ 1 Never Married 2 Married Baltimore, Maryland 21215-0036 If Yes, Give Year or Dates 1 ☐ Yes 2 🔀 No Specify Specify: white 3 Widowed 4 Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) should be filed with and Mental Hygien is marked other th lighting sales sales Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) 2 Charlotte Meseke August Hoffman permit. Page 1 and 2 should be Department of Health and Men Important: If item 27 is marke any injury or other traumatic. 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Andrea Hoffman, daughter 810 Clearview Avenue, Hampstead, Md. 21074 20a. Method of Disposition 20b. Place of Disposition (Name of Date 20c. Location - City or Town, State 1 ★ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) cemetery, crematory or other place) 12/22/2009 Hampstead, Md. Hampstead Cemetery 21. Signature of Funeral Service Licenses 22. Name and Address of Facility Eline Funeral Home 934 South Main St., Hampstead, 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ disease or condition Medical resulting in death) as a consequence of Examiner Sequentially list conditions Examine if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury that initiated events Due to for as a consequence of To the Hospital or Attending Physician; The law requires that the death certificate be executed tran Due to (or as a consequence of) resulting in death) Last burial-1 physician the burial Physician/Medical Box 68760 attending p for use as t IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ in the past 12 months? Pregnant at time of death the 9 Unknown 9 Unknown signed by the Division of Vital Records, P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ş Completed 1 2 2 No 3 Probably 4 Unknown page 2 should 24b. Were autopsy findings available prior to completion of cause of 24a. Was an certificate has autopsy death? 2 240 1 Yes ☐ Yes 2 YA 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Hospital 2 🗆 No မ 1 Empatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) this To the Funeral Director; After thi completed filled in by the funeral 28a. Date of injury (Month, Day, Year) 27. Manher of Death 28b. Time of 28c. Injury at Certificate: 28d. Describe how injury occurred injury work? 1. ☐ Yes 2 ☐ No 5 Pending death. Accident Investigation 6 Could not be Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number. 4 Homicide after determined City or Town, State) within 24 hours a To the Funeral I Medical 29a, Certifier 🔁 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On 🖋 basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated (Check Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and tile of certifie 29c. License number 29d. Date signed (Month. Day. Year) 200

State Registrar Registrar's Signatur

NNO

21403

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

31. Date filed (Month, Day, Year

			1 - State Registrar			Certi	ficate of	Death	1		Reg. N	. 20	0.9	42	82
			1. Decedent's Name (First, Middle, La	st)					2	2. Date of De		ay	Year	3. Time o	of Death
и	Physicia /Medic		ROSE	MARIE	HURI)			n	DECEMB		20 2		1:15	5 A ^M
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	the N	Director	DELAWARE SUSSE 10e. Street and Number	Λ	SEL	_BYVI	10f. Zip Code				10a. C	Citizen of W	/hat Cour	ntrv?	
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	ns 20	Funeral	11. Marital Status	12. Was Decedent E	ver in U.S.	13. Was	199 s Decedent of	Hispanic O	rigin? (Speci	ify Yes or No	0-	US.		can Indian,	
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2-0	filed within 72 hours after death with the Maryland Hygiene. vther than "natural", or items 23a or 28a-f show ent, the Medical Eventine in the matter	Completed	15. Decedent's E (Specify only highest gr	ducation	16a.	Deceden	nt's Usual Occu	pation	et of working	···	16b.	Kind of Bu	siness/Ind	dustry	
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2	ad wi	Sol		4		RE	EGISTER	1				HEAL		RE	
p	be file tal H d oth	Be	17. Father's Name (First, Middle, Last					18. Moth	ner's Name (First, Middle	e, Maide	en Surname	9)		
<u>₹</u>	Men Men arke	은	LUIS P	ORTO				K	ATHLEE	EN	((UNKN	OWN)		
ā	2 short and is m		19a. Informant's Name/Relationship				Address (Stree								
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0	ges 1 t of h if ite or ot		20a. Method of Disposition 1 ☐ Burial 2 【XCremation 3 ☐	Removal from State	20b. Place of cemeter	Disposition y, cremate	on (Name of ory or other pla	ice)	Dat	te	20c. I	Location -	City or 10	wn, State	
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Baltimore, Maryland 21215-0036	permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any Injury or other traumatic event, the Wedical Eventions in ust be conflicted event.		21. Signature of Funeral Service Lice	nsee			lame and Addr		•		_				
	⊕ □ <u>=</u> @ O		July 1	This	7		STINGS					VILLE	, DE		
			23a. Part : Enter the disease, or com shock, or heart failure. List only						,		arrest,			Approxima Interval Be Onset and	etween Death
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Ē	ding F h. After funera	ü	27. Manner of Death 1 Natural 5 ☐ Pending	28a. Date of Injur (Month, Day	y Year) 28b. T	ime of njury	28c. Inju			3d. Describe	how inj	jury occurre	ed		
<u>S</u>	tend leath tor: / the f	cat	d Accident investigation 3 Suicide 6 Could not be					Yes 2							
Division of Vital	or At after of Direction by	Certification:	4 ☐ Homicide determined		ry - At nome, tar . <i>(Specify)</i>	m, street	, тастогу, опісе		28	If, Location City or To	(Street a own, Sta	and Numbi ite)	er or Hura	ม Houte Nu.	mber,
_	pital Surs a eral I		29a. Certifier Sertifying P	hysician: To the best of	f my knowledge	death o	ccurred at the	time dates	and place as	nd due to th	0.031160	(e) and ma	nnor ac	etatod	
	To the Hospital or Attending PI within 24 hours after death. To the Funeral Director: After the completely filled in by the funeral process.	Medical	(Check only one)	miner: On the best of and manner sta	examination and	d/or inves	stigation, in my	opinion, de	eath occurre	d at the time	e cause e, date a	ind place, a	and due to	o the cause	(s)
	othe othe ompl	Me	29b. Signature and title of certifler				29c. Licen	se number			29d. D	Date signed	(Month,	Day, Year)	
	->-0		1 A	2	~		MAR	(7	40		12/21/20				
	mr.		30. Name and address of person who	completed cause of de	eath (Item 23a) (Type, Pri	nt)	- 6	100			-	, 107		
	M		CHURAN WAN	1 1.2		737	CAC	1/12	wy	u	N	7	117	02	
	Sta	te	31. Date filed (Month, Day, Year)	32. Registra	r's Signature	1		- 6							
	Registr	ar	UEU Z 1	2009 Denes	m d.	100	the								

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ December 2009 Sidney Saul Haas Medical 4a. Facility Name (If not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death Montgomery General Hospital Olney If Under 1 Year If Under 24 Hrs. 5. Social Security Number **Funeral** 7. Age (In yrs. last birthday) 8. Date of Birth 1 X M 2 🗆 F Days Hours 01/05/1934 105-24-6689 Director Usual Residence of Decedent should be filed within remember and Mental Hygiene.
77 is marked other than "natural", or items 23a or 28a-f show the marked other than "natural", or items 25a or 28a-f show marked other the Medical Examinar must be notified at 10a. State 10b. County 10c. City, Town or Location Director Silver Spring Maruland Montgomery 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 15808 Radwick Lane 20906 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates. 13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Completed by 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 🗓 No Specify: 3 X Widowed 4 Divorced 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business Industry (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) Educational Book Salesman Department of Health and Mental Hygi Important: If item 27 is marked other any injury or other traumatic event, I Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ပ Benjamin Haas Sadie Eksterling 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) .. Page 1 and 2 sl tment of Health a <u> Eileen B. Wiggs - Daughter</u> Crocus Terrace, Ashburn, Virginia 20147 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place Date 20c. Location - City or Town, State 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Portation 5 ☐ Other (Specify) Judean Memorial Gdns. 12/22/2009 | Olney, Maryland of Funeral S rvice Lig 22. Name and Address of Facility Hines-Rinaldi Funeral Home. 21. Signatur M00/0 11800 New Hampshire Ave., Silver Spring, part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or hear vailure. List only one cause on each line. Immediate Cause (Final disease or condition Cardiovascular Sisease Physician/) Medical resulting in death) Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Due to (or as a consequence of): Examir that the death certificate be executed Cause (Disease or linjury that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ in the past 12 months?
1 ☐ Yes 2 ☐ No ate has been signed by the atte page 2 should be detached for Month P.O. Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Mellitus Records, 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 X Unknown Completed Hypertension 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? Yes 2 X No To the Hospital or Attending Physician: within 24 hours after death.

To the Funeral Director: After this certifical completed filled in by the funeral director, I 25. Was case referred to medical Division of Vital Certificate: To Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 De Yes 2 □ No 1 Inpatient 2 R/Outpatient 3 DOA 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of injury 28c. Injury at 28d. Describe how injury occurred 1 Natural 5 Pending 1 Yes 2 🗌 No 2 Accident
3 Suicide
4 Homicide Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State Medical 29a. Certifier 1/Excertifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

| Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated lle Chierdese, MIS 1)0028429

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

3. Time of Death

Montgomery

U.S.A.

Education

9. Birthplace (State or Foreign Country) New York

White

Approximate Interval Between Onset and Death

Mears

Dav

Year

10d. Inside City Limits

1 Yes 2 X No

8:11рм

Registrar DHMH 17 Rev 7/2009

State

back

18101

Prince Phillip Orive

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Montgoinery (veneral Item)

31. Date filed (Month, Day, Year)

		Please 1 - State Registration and ed #26, W	Type or Print in State of Maryla	nd / Depa	artment		d Mental Hy			42823		
Physici /Medio		1. Decedent's Name (First, Middle, La	getta Hood				2. Date of De December	ath	2009	3. Time of Death 9:40 pm		
Examir		4a. Facility Name (If not institution, giv 32 Anchor Way	e street and number)			own, or Location of De	eath		ounty of Death Cester			
Funeral Director		220 03 2307	Sex 7. Age (In yrs ☐ M 2 🛛 F 91	s. last birthday) Yrs.	If Under 1 Months (Hrs. 8, Date of Bir (Month, Da 01/31	th ay, Year) /1918	Cour	place (State or Foreign stry) ryland		
faryland	ō	Usual Residence of Decedent 10a. State 10b. County Maryland		ity, Town or Lo					1	0d. Inside City Limits 1 □ Wes 2 □ No		
with the Magarith	Funeral Director	10e. Street and Number 1115 Roland He:		II CIMOL	10f. Zip C	ode 211		10g. Citizen of What Country? USA				
ges 1 and 2 should be filed within 72 hours after death with the Maryland it of Health and Mental Hygiene. If flem 27 is marked other than "natural", or items 23a or 28a-f show or other traumatic event, Its Medical Examinar must be notified at	þ	11. Marital Status 1 Never Married 2 Married 3 Midowed 4 Divorced	12. Was Decedent Ever in the Armed Forces? 1 Yes 2 No if Yes, Give Year or Dates:		Was Deceder If Yes, specify 1 □Yes 2		14. Race - American Indian, Black, White, etc. Specify: white					
ithin 72 ho ne. han "natur	Completed	15. Decedent's Ec (Specify only highest gra Elementary/Secondary (0-12)	ducation ade completed) College (1-4or 5+)	(Give life. I	DO NOT use	done during most of tretired)	working		of Business/Ind	·		
vuld be filed with Mental Hygiene. arked other tha atic event, The	Be	17. Father's Name (First, Middle, Last) Thomas Brazier	-	rece	<u>otioni</u>	18. Mother's f	Name (First, Middle,	, Maiden Su	lth car	:e		
and 2 should ealth and Me n 27 is mark her traumati	ပ္	19a. Informant's Name/Relationship (Jackie Weitzell/c	19a. Informant's Name/Relationship (Type. Print) Jackie Weitzell/daughter 19b. Mailing Address (Street and Number or Rural Route Number, City on 32 Anchor Way, Berlin, MD 2181									
permit. Pages 1 and 2 s Department of Health ar Important: If Item 27 is any injury or other trau			Oa. Method of Disposition 1 Burial 2 XCremation 3 Removal from State 4 Ponation 5 Other (Specify) 1 Signature of Euneral Service Licensee 20b. Place of Disposition (Name of cemetery, crematory or other place) Salisbury Crematory 12/21/09 Salisbury 12/21/09 Salisbury 12/21/09 Salisbury 12/21/09 Professional									
Physician /Medical Examiner pontial-transit	al Examiner	3a. 7rt1. Enter the disease, or com shock, or heart failure. List only mmediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	a. Due to (or as a conse b. Due to (or as a conse c. Due to (or as a conse	th. Do not ent tic Cav quence of): Cancel quence of):	er the mode	ow Hill Ro	diac or respiratory a	oury M	ID 21804	Approximate Interval Between Onşet and Death menins		
To the Hospital or Attending Physician: The law requires that the death certificate within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physicompletely filled in by the funeral director, page 2 should be detached for use as the beautified.	Physician/Medical	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	23c. If yes, outcome of pregr 1		23d. Date of delivery Month Day							
equires that the sen signed by ould be detail	ठ्	Part II. Other significant conditions of Pathologic F	contributing to death but not re	sulting in the ur	nderlying cau	se given in Part I.		obacco use		ne cause of death?		
r: The law licate has b	Completed		U				— 24a. Was — autoj perfo 1 □Yes	psy ormed?	prior to co death?	psy findings available mpletion of cause of		
g Physicla ier this certi ieral directo	n: To Be	25. Was case referred to medical examiner? 1 Yes 2 No 27. Manner of Death	Hospital: 1 ☐ Inpatient 2 ☐ 28a. Date of Injury (Month, Day, Year)	ER/Outpatier			g Home 52 Resi	dence 6 P		r's Residence		
To the Hospital or Attending Physician: The law within 24 hours after death. To the Funeral Director: After this certificate has completely filled in by the funeral director, page 2 s	Certification:	1 Abatural 5 Pending investigation 3 Suicide 6 Could not be determined		nome, farm, stre	M eet, factory, o	1 ☐Yes 2 ☐ No	28f. Location (City or To	Street and N wn, State)	lumber or Rura	al Route Number,		
ne Hospit n 24 hours ne Funera pletely fille	Medical ((Check only 2 Medical Examone)	nysician: To the best of my kr niner: On the basis of examir and manner stated.	nation and/or in	vestigation, ir	n my opinion, death o	ccurred at the time,	date and pl	nd manner as s ace, and due to	stated. o the cause(s)		
To the To the comment	M	30. Name and address of person who Glenn Ic. Avea do: 31. Date filed (Month, Day, Year) DEC 23 20	ND		29c. l	icense number	5	29d. Date s	igned (Month,	Day, Year)		
287		30. Name and address of person who Glenn Ic. Arzado	completed cause of death (Ite 9714 Health	em 23a) (Type,	Print)	Berlin 1	nD 218	11	-			
Sta Registr		31. Date filed (Month, Day, Year)	32. Registrar's Sign	ature &	and I							

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

			_ For	State of Ma	aryland	/ Depa	artment of I	Health and	Mental Hy	giene	3	
			1 - State Registrar			Ce	rtificate of	Death		Reg. No. 2	009	42824
H	Physici /Medio		1. Decedent's Name <i>(First, Middle</i> Hildegarde	G. Hard	ly				2. Date of De Month	Day	Year 2009	3. Time of Death
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-140				6. Sex 7. Ag	e (In yrs. la		If Under 1 Year	DWY If Under 24 Hrs	8. Date of Bir		9 Birthi	place (State or Foreign
	Funeral Director		219-05-7795		88	Yrs.	Months Days	Hours Min		/1921	Cour	ryland
	land ow		Usual Residence of Decedent 10a. State 10b. County		10c. City,	Town or Lo	ocation				1	0d. Inside City Limits
	8a-f sh	ector	Maryland Wico	mico	Sali	sbury						1 XYes 2 □ No
	3a or 2	Funeral Director	10e. Street and Number 300 Lemon Hi	ll Lane			10f. Zip Code 2180.	l		10g. Citizen	of What Cou SA	ntry?
	ems 2	iner	11. Marital Status	12. Was Decedent I Armed Forces?	Ever in U.S	. 13.	Was Decedent of H If Yes, specify Cub	Hispanic Origin? (Specify Yes or No	- 14. [Race - Ameri	
980	72 hours after death with the Maryland 'natural', or items 23a or 28a-f show deal Evanther roust be notified at		1 ☐ Never Married 2 ☐ Marri 3 🛣 Widowed 4 ☐ Divorced		No		1 □Yes 2 🔼 No	Specify:	10 1110011, 0.0.7			nite
5-0	72 hor	eted	15. Decedent	's Education		16a. Dece	dent's Usual Occup	pation during most of we	orkina i	16b. Kind o	f Business/In	dustry
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/lar	should be fi and Mental P s marked of umatic ever	10 B	Ewald Newman					Wilhe	mena Rup	part		
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Baltimore,	es 1 a of Hea		20a. Method of Disposition 1 ☐ Burial 2 🎛 Cremation	0	20b. Pla	ace of Dispo metery, crei	osition (Name of matory or other pla	ce)	Date	20c. Location	on - City or To	own, State
ij	tment tant; I tant; I		4 Denation 5 □ Other (S)	pecify)	Sal		y Cremato		′20/09		bury,	
Bal	permit. Pages 1 and 2 Department of Health a Important: If item 27 is any injury or other tra <u>once.</u>		21. Signature of Funeral Service	_icensee/		2:	HOTTOWAY 501 Snow	Funeral Hill Rd	Home Pro	ofessi bury,	onal A MD 218	ssociation 04
			23a. Prt1. Enter the disease, or shock, or heart failure. List	complications that caused only the cause on each lit	the death. ne.	Do not en	ter the mode of dyi	ng, such as cardi	ac or respiratory a	rrest,		Approximate Interval Between Onset and Death
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O. Box	The law requires that the death certificate be executed are has been signed by the attending physician and bage 2 should be detached for use as the burial-transit	Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 ☑ No 9 □ Unknown	23c. If yes, outcome 1 ☐ Live birth 4 ☐ Pregnant a 9 ☐ Unknown	2 Fetal	death 3	☐ Ectopic pregnand ☐ Other (specify) _	Э		23d.	Date of deliv Month	ery Day Year
σ.	res that t signed by be detac		Part II. Other significant condition	ns contributing to death b	ut not resul	ting in the u	nderlying cause giv	en in Part I.	23e. Did t	obacco use c	ontribute to t	he cause of death?
ords	v requires been sign should be	ed by							. 1 🗆 '	Yes 2□N	o 3□ Pro	bably 4 Unknown
Records,	The law recate has be page 2 sho	Completed							24a. Was autor perfo	osy rmed?	prior to co death?	opsy findings available ompletion of cause of
Vital	i ician; Th certificate ector, pag	Ø.	25. Was case referred to medical					26. Place of De	1 ☐ Yes eath (Check only o	2 No	1 🗆 Yes	2 □ No
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o uc	fte fte	ion	27. Manner of Death 1 Natural 5 Pending		ry y, Year)	28b. Time o Injury	Wor	ryat k? ÌYes 2 □ No	28d. Describe	how injury oc	curred	
Division	To the Hospital or Attending within 24 hours after death. To the Funeral Director: Afte completely filled in by the fune	Certification:	2 Accident investig 3 Suicide 6 Could r 4 Homicide determi	not be 200 Place of Inju	ury - At hor c. <i>(Sp</i> ec <i>ify,</i>	ne, farm, str	reet, factory, office	ires 2 🗆 No	28f. Location (Street and Nu vn, State)	ımber or Rur	al Route Number,
	ospital hours a uneral Daly filled		29a. Certifier 12 Certifyin (Check only 2 Medical	g Physician: To the best Examiner: On the basis o	of my know	vledge, deat	th occurred at the t	ime, date and pla	ce, and due to the	cause(s) and	d manner as	stated.
	To the H within 24 To the Fi complete	Medical	one)	and manner sta	ated.	on and/or If	29c. Licens		Juneu at the time,			
	\$ \$ \$ \$ \$	=	29b. Signature and title encertifier	M.)						29d. Date sig		
	tou!		30. Name and address of person	who completed cause of d	leath (Item	23a) (Type,	Print) NOLL S:	1 00	1. 1			
	Sta	te	31. Date filed (Month Day, Year)	32. Registra	ar's Signati	CATT	WILL D	- DA	lisbur	y M	9 0	11801

DHMH 17 Rev 1/2001

Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 2 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month **Physician** Ye ar bert 2009 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Tanyland Medical Center University 5. Social Security Number Timore 1 Year | If Under 24 Hrs. If Under Birthplace (State or Foreign Country) Age (In yrs. last birthday) Date of Birth (Month, Day, Year) **Funeral** 10 M 20 F Months Days Hours 214-42-4685 Director Aug. 31, 1945 Maryland Usual Residence of Decedent Pages 1 and 2 should be filed within 72 hours after death with the Maryland ment of Health and Mental Hygiene. ant: If item 27 is marked other than "natural", or items 23a or 28a-f show ury or other traumatic event, the Medical Evantiner must be notified at 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits 1 □ Yes 2 □ to Director Maryland Charles LaPlata 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 7535 Annapolis Woods Road 20646 Funeral U.S.A. 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 ∐Yes 2 ☐ If Yes, Give Year or Dates: 2 No 1 Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 1□Yes 2□No Specify: 9 Specify: 3 Widowed 4 Divorced Black Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Pipefitter Construction Company 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Albert Jackson, Sr. Alberta Gutrick ပ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Mary Hodgson Sister 5810 Northwood Dr., Barltimore, Md. 21212 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State permit. Pages Department of Important: If it any injury or o once. 1 ☐XBurial 2 ☐ Cremation 3 ☐ Removal from State 2009 Nanjemoy, Maryland 4 ☐ Donation 5 ☐ Other (Specify) Mount Hope Baptist Church 21. Signature of Funeral Service 22. Name and Address of Facility Williams Funeral Home, P.A. M00668 4270 Hawthorne Rd., Indian Head, Md. 20640 23a. Part 1. Enter the shock, or he art foliure. Immediate Caus Africal disease or condition resulting in death) ease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, re. List only one cause on each line. Approximate Interval Between Onset and Death **Physician** Aastroint Estinal bleeding Iday /Medical Due to (or as a consequence of): Examiner uu to (or as a consequence of) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner e Hospital or Attending Physician: The law requires that the death certificate be executed 24 hours after death. e Funeral Director: After this certificate has been signed by the attending physician and and burial-trai Due to (or as a consequence of): P.O. Box 68760, attending physician for use as the buria Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? Day Year ☐ Pregnant at time of death 5 ☐ Other (specify) 1 ☐ Yes 2 ☐ No sate has been signed by the page 2 should be detached 9 Unknown Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Records, þ 1 Yes 2 No 3 Probably 4 Unknown Completed Chronic Obstructive 24b. Were autopsy findings available prior to completion of cause of death? autopsy performed? Yes 2 No Division of Vital 1 🗆 Yes 1 ☐ Yes 2 ☐ No 25. Was case referred to medical examiner? director, Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To completely filled in by the funeral 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 5 Pending investigation 1 Natural 1 ☐ Yes 2 ☐ No 2 Accident 3 Suicide 6 Could not be determined 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide Medical 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. To the within 2 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year)

Registrar

State

30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Kim Bizzell

strar's Signature

Please Type or Print in Black Indelible Into Taxon All Copies Are Legible.
State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Month Ann Jones Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death WICIMIO PONINSUUS REGIONAL MIOICA 59/15640 8. Date of Birth (Month, Day, Yea 1-5-1975 If Under 1 Year If Under 24 Hrs. 9. Birthplace (State or Foreign Country) North Carolina 7. Age (In yrs. last birthday) **Funeral** 1 □ M 2 🗓 F Months Hours Min. Director 242-65-9615 Usual Residence of Decedent permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hyglene. Important: I firem 27 is marked lyglene, Important: I firem 27 is marked than "natural", or items 23a or 28a-f show any injury or other traumatice event, the Medical Examiner must be notified at any injury or other traumatic 10a. State 10c. City, Town or Location 10d. Inside City Limits Director 1 X Yes 2 No Wicomico MD Salisbury 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 609 Terrapin Lane 21804 USA 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Armed Forces?

1 Yes 2 No Black, White, etc. ş 1 Never Married 2 X Married Baltimore, Maryland 21215-0036 If Yes, Give Year or Dates 1 ☐ Yes 2 🔀 No Specify: White Specify: Completed 3 Divorced 4 Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) 12 Waitress Restaurant Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ပ John Setzer Caro1 King 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 609 Terrapin Lane, Salisbury, Maryland 21804 Thomas E. Jones - Husband 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State cemetery, crematory or other place) 1 Burial 2 X Cremation 3 Removal from State 4 ☐ Donation 5 ☐ Other (Specify) rematory of Delmarva 12-18-2009 Delmar, Delaware 22. Name and Address of Facility Bounds Funeral Home Formal Service Licensee 705 E. Main Street, Salisbury, Maryland 21804 23a. Part 1. Enter the disease, or construction of the shock, or heart failure. List only of plications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Priysician/ disease or condition) Medical resulting in death) Due 1 (or as a consequence of) Examiner Sequentially list conditions, if any, reading to immediate cause. Enter Underlying Examine Due to for as a consequence of: Cause (Disease or linjury that initiated events Due to (or as a consequence of) resulting in death) Last Physician/Medical P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ in the past 12 months?

1 Yes 2 No
9 Unknown Pregnant at time of death
Unknown Day Part II. Other significant conditions contributing to death but pet resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by Division of Vital Records, 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an 1 Tes 25. Was case referred to medical Be 26. Place of Death (Check only one) 1 Yes 2 □ No Other: 1 Inpatient 2 ER/Outpatient 3 DOA မ 4 Nursing Home 5 Residence 6 Other (Specify, 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at Certificate: 28d. Describe how injury occurred 1 Natural 5 Pending 1 🗌 Yes ☐ Accident ☐ Suicide Investigation 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide City or Town, State) Medical 29a Certifier within 24 hou

To the Fune

completed fi Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. (Check Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Certifying Nurse Practioner. To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated of_certifie D44688 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Registrar
DHMH 17 Rev 7/2009

State

31. Date filed (Month, Day, Year)

09-10020 Roger Johnson

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible

Roger Johnson		1- For State	rland / Departm	ent of He ate of De	ealth and Mental	Hygiene	2009	4282
Physic	ian	Registrar 1. Decedent's Name (First, Middle, Last)	Certifica	——————————————————————————————————————	<u>atri</u>	2. Date of Deat	g No.	7 tun (4) tun
Medical Exam		Roger Thurma	in John	1110	Tr	Month December		3. Time of Death 2046 hrs
		4a. Facility Name (if not institution, give street and	number)	4b. Cit	y, Town, or Location of De		4c. County of Deat	
		Sinai Hospital		Ва	ltimore			
Funeral Director		5. Social Security Number 6. Sex	7. Age (In yrs. last birtl	• —	Inder 1 Year If Under 24		h(MM/DD/YYYY) 9. Bir Forei	
Director		216-54-9049 1XM 2 F	59	Yrs.	nths Days Hours N	Jan 2	2,1950 0	ountry) Maryland
any		Usual Residence of Decedent 10a. State 10b. County	10c. City, Town	or Location				
A		NA	lo ii					10d. Inside City Limits 1 Yes 2 No
arylan 8a-f s	cto	10e. Street and Number	1 Dalti	more	Zip Code	110	g. Citizen of What Cou	
11215-0036 Id be filed within 72 hours after death with the Maryland Aental Hygiene. narked other than "natural", or items 23a or 28a-f show event, the Medical Examiner must be notified at once.	Director	3917 Deschartes	Dood.		21207	, ,	g. Gitizon of What God	- 1 A
with ns 23.	uneral		ecedent Ever in U.S.	13. Was Dece	edent of Hispanic Origin? (Specify Yes or No-	14. Race - Amer	ican Indian, Black,
death or iten	ŭn.	1 Never Married 2 Married 1 X Yes	Forces?		ecify Cuban, Mexican, Puer		White, etc.	, Diadit,
s after ral", o	by F	3 Widowed 4 Divorced If Yes, Give Y	ear		2 X No specify:		Specify: B	iack
hour:	ted	15. Decedent's Education (Specify only highest gr	d	ecedent's Usu luring most of v	al Occupation (Give kind overking life, DO NOT use n	f work done	16b. Kind of Business/	ndustry
36 hin 72 e. than dical	Completed	Elementary/Secondary (0-12) College	(1-4 or 5+)		Cil	,	is A.	.0411
ed with	Som	17. Father's Name (First, Middle, Last)			18 Mother's Nar	ne (First, Middle, M		my
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ID 21215-0036 should be filed within 72 hours after death with the Maryland and Mental Hygiene. 7 is marked other than "natural", or items 23a or 28a-f she natic event, the Medical Examiner must be notified at once	ပ	19a. Informan Name/Relationship (Type, Print)	19b.	Mailing Addre	ess (Street and Number o	Rural Route Numb	er, City or Town, State	, Zip Code)
nore, MD 2 ages I and 2 shou at of Health and It: If item 27 is n other traumatic		Donis Handy Si	ster 4		ainson St.	Salisby	ry Maryla	and 21801
of He		20a. Method of Disposition 1 V Burial 2 Cremation 3 Removal		Disposition (N ry or other plac	ame of cemetery,	Date	200 Location - City or	Town, State
Baltimore permit. Pages 1 a Department of He Important: If its		4 Ronation 5 Other Specify:	Maryl	and Vet	terans Cem Jo	in 4,2010	Huclark	MD
Baltimo permit. Page Department (Important: injury or otl		21. Sign ture of Funeral Service Licensee		22. Name ar	nd Address of Facility	tewart	Funeral	Home_
Physician	_	23a. Part I. Enter the disease, or complications that	caused the death. Do not	1821	West Road	Salisbu	ing, Maryl	and 21801
//Medical		landre. List only one cause on each line.					t, s hock, or neart	Approximate Interval Between Onset and
Examiner		Immediate Cause (Final disease or condition resulting in death) a. Acute Due to (or as	pneumonia & a consequence of):	Purule	ent pleuritis			Death
	_	Sequentially list conditions, b						
	ine	cause. Enter Underlying Cause	a consequence of):					
7 1	Examiner	(Disease or injury that initiated events resulting in death) Last Due to (or as	a consequence of):					
be executed sician and unial - transit		d.						
O, e be ex sician burial	edical	■ AMENDED AMENDED	23a,27,per	mE, g89	9 1/11/10 TI	•		
Box 68760 death certificate b he attending physid for use as the bu	sician/Me	3b. Was decedent pregnant in the	outcome of pregnancy				23d Date of delivery	
x 6 th cert ttendir	icia	past 12 months?	nant at time of death 5	Other (Sp		ancy	Month D.	ay Year
Bone deat	Phys	1 Yes 2 No 9 Unknown 9 Unkn						11
Division of Vital Records, P.O. Box 68760. Hospital or Attending Physician: The law requires that the death certificate 24 hours after death. Funeral Director: After this certificate has been signed by the attending physicial filed in by the funeral director, page 2 should be detached for use as the beautified in by the funeral director, page 2	징	Part II. Other significant conditions contributing t	o death but not resulting i	n the underlyin	ng cause given in Part I.		acco use contribute to the	
duires en sign						1 Yes	2 No 3 Proba	abiy 4 🗸 Unknown
cords law requir	ompleted					24a. Was an autopsy	prior to co	opsy findings available ompletion of cause of
Division of Vital Records, tal or Attending Physician: The law requirers after death. al Director: After this certificate has been sited in by the funeral director, page 2 should be	힝					performe 1 ✓ Yes 2	ed? death? No 1 🗸 Yes	2 No
ician:	å	25 Was case referred to medical examiner? Hospital:			26.Place of Death (Check	- · · ·		
of V Phys er this	의	1 Yes 2 No	inpatient 2 FR/Outp	ne of Injury			esidence 6 Other	
ion c tending eath. for: Aft	<u>[]</u>	27 Manner of Death 28a. Date (Month	, Day, Year)	ne or injury	28c. Injury at Work?	28d. Describe hov	v injury occurred	
ivision or Atten after death Director: in by the	<u>[</u> g	2 Accident Investigation	e of Injury - At home, farm	n street factor		28f Location (Stre	eet and Number or Rura	al Bouto Mumber City
Divospital or hours aft	Certification:	3 Suicide 6 Could not be determined (Specify)	o o myany ya nomo, igin	i, oli oot, ractor	y, omee banding, etc	or Town, State		al Route Number, City
Hosp 24 ho Fune stely f		19a. Certifier 1 Certifying Physician: To the bes	t of my knowledge, death	occurred at the	e time, date and place, and	due to the cause(s	and manner as stated	1
Divisi To the Hospital or Att within 24 hours after de To the Funeral Direct completely filled in by	Medical	ne) 2 Medical Examiner: On the basis of and manner s	of examination and/or inve	estigation, in m	y opinion, death occurred	at the time, date and	d place, and due to the	cause(s)
	Ž	9b. Signature and title of certifier		29	c. License number	2	9d Date signed (Mont	h, Day, Year)
		and Is			O.C.M.E.	[December 24, 200	9
		O. Name and address of person who completed caus						
		Ana Rubio MD. Assistant Medical E	xaminer 111 Pe	nn Street, I	Baltimore, MD 2120			
Sta Registr	te ar	1 Date filed (Month, Day Year) 4 2010 32. Re	strar's Signature	park				

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

			For State	State of Mar	yland	-	rtment of H tificate of D		nd Mei		2009	42828	
			Registrar 1. Decedent's Name (First, Middle, Las	,		007	incare or E	Catri	2.	Date of Death	,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,	3. Time of Death	
Pl	nysicia Medic		Virginia S. Ke							12 1	7 200 9 Pear	3:30 a M	
[/]	xamin		4a. Facility Name (If not institution, give 3422 Murray Road	street and number)			4b. City, Town, or Finksbur		Death		4c. County of Death Carroll		
	ineral rector		202 12 27 10	7. Age (// M 2 X F 62	'n yrs. last	t birthday) Yrs.	If Under 1 Year Months Days	If Under 24 Hours N		Date of Birth (Month, Day, You (arch 10	9. Birth Cou	nplace (State or Foreign ntry) KY	
pue	show	ō	Usual Residence of Decedent 10a. State 10b. County	1		Town or Loc						10d. Inside City Limits	
Maryia	28a-f	irect	MD Carroll		Fin	ksbur	g					1 ☐ Yes 2X No	
ר with the	ns 23a or nust be n	Funeral Director	10e. Street and Number 3422 Murray Road				10f. Zip Code 21048			10	g. Citizen of What Cou USA	intry?	
)036 Irs after deatl	11. Marital Status 1 Never Married 2 Married 1 Never Married 2 Married 3 Widowed 4 Divorced 12. Was Decedent Ever in U.S. Armed Forces? 1 Yes 2 No If Yes, specify Cuban, Mexican, Pue 1 Yes 2 Mo 1 No 1						? (Specify uerto Rica	Yes or No- an, etc.)	14. Race - Ameri Black, White, Specify: Whi	etc.			
15-0 72 hou	"natu edical	Completed	15. Decedent's Education 16a. Decedent's Usual Occupation (Specify only highest grade completed) (Give kind of work done during most of work								6b. Kind of Business II	ndustry	
2127 vithin 7	r than the M	Con	Elementary/Seconday (0-12)	College (1-4 or 5+)			NOT use retired)			h	neating & A	A/C	
land he filed v	rked othe tic event,	To Be	17. Father's Name (First, Middle, Last) David Donovan					18. Mother's Savann	,	irst, Middle, Ma aylor	iden Surname)		
, Mary of 2 should salth and N	n 27 is me er trauma		19a. Informant's Name/Relationship (7) Richard J. Kenny								ity or Town, State, Zip 21048	Code)	
Baltimore, Maryland 21215-0036 permit. Page 1 and 2 should be filed within 72 hours after Department of Health and Mental Hygiene.	20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place)							Date	20c. Location - City or Town, State Sykesville, Md.				
Balt permit. Departr	Import any inji once.		21. Signature of Funeral Service Licens Page Hardy	_	t Funer 11e, MI	al Home & 21784	Chapel						
) Me	ician/ edical		23a. Part 1. Enter the disease, or com shock, or heart failure. List only o Immediate Cause (Final disease or condition resulting in death)	a. Due to (or as a co	diac or re	spiratory arrest		Approximate Interval Between Onset and D. at					
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o pe exec	g physician and s the burial-transit	edical E	resulting in death) Last	Due to (or as a co	onsequer	nce of):							
8760 tificate b	ng phy as the	Med	IF FEMALE:	u									
Division of Vital Records, P.O. Box 68760 To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.	/ the attendi	Physician/M	23b. Was decedent pregnant in the past 12 months? 1 Yes 2 No 9 Unknown	23c. If yes, outcome of particles of Live Birth 2 Live Birth 2 Pregnant at tire 9 □ Unknown	Fetal o	leath 3 🔲	Ectopic pregnancy Other (specify)	у			23d. Date of deliver Month	very Day Year	
ds, P.O	en signed bruild be deta	by	Part II. Other significant conditions of	ontributing to death but i	not result	ing in the ur	derlying cause give	en in Part I.	_		2 No 3 Pro	the cause of death?	
Recor	r tnis certificate nas be rral director, page 2 shc	Completed							_	24a. Was an autopsy performe	prior to co	opsy findings available ompletion of cause of 2 No	
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Division of the rate of a street dear	d in by the	Certificate:											
le Hospita	oleted fille	Medical	29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check only one) 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.										
	thuo JL		29b. Signature and title of certifier	1 A 200	aul	7	29c. License			290	d. Date signed (Month,		
	5		30. Name and address of person who c				int)					;	
R	Stat egistra		31. Date filed (Month, Day, Year)	32. Registrar's	Signature	e	harri						

DHMH 17 Rev 7/2009

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month KTNG DECEMBE 18 2009 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death HOPKYNS IMORF (ITY 5. Social Security Number Date of Birth (Month, Day, Year 1964 7. Age (In yrs, last birthday) If Under 1 Year | If Under 24 Hrs. 9. Birthplace (State or Foreign Collect Africa 213-33-2221 August 30. Sierra Leone, Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Maryland ¥Yes 2□No Howard Savage 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country?
Sierra Leone,
West Africa 8556 Storch Woods Drive; Apt. 1B 20763 12. Was Decedent Ever in U.S. Armed Forces?

1 ☐ Yes 2 ▼ No
If Yes, Give 11. Marital Status Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 Never Married 2 Married 1 □Yes 2X No 3 Widowed 4 Divorced Specify: Black Year or Dates 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Assisting Living Elementary/Secondary (0-12) College (1-4or 5+) Licensed Practical Nurse years Group Homes 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Lwald Charlie King Christiana Mary Palmer 19a. Informant's Name/Relationship (Type. Print) (Daughter) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Christiana Ishamatus Fofana 8556 Storch Woods Drive; Apt. 1B; Savage, Maryland 20763 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 Burial 2 ☐ Cremation 3 ☐ Removal from State Dec.26,2009 4 Donation 5 DOther (Specify) Gate of Heaven Cemetery Silver Spring, Maryland 21 Signature of Funeral Service Licenses 22. Name and Address of Facility R. N. Horton Company Morticians, Honday Inc.;600 Kennedy Street, N.W.; Washington, D.C. 20011 23a. Part 1. Enter the disease, or complications that a used the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Onset and Death Multiorgan Due to (or as a consequence of): bucheren (01: Sequentially list conditions, cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Cutin's Due to (or as a consequence of): Cancer SIP chen Metuskiti IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery in the past 12 months? 3 🔲 Ectopic pregnancy Month 4 ☐ Pregnant at time of death Yes 2□No 5 Other (specify) 9 X Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 Yes 2 → No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed 1 □Yes 2 1No 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1- Inpatient 2 ER/Outpatient 3 DOA 28a. Date of Injury (Month, Day, Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 5 Pending investigation 1 ☐ Yes 2 ☐ No 6 Could not be determined

Physician /Medical Examiner Examiner

and

Physician

/Medical

Examiner

Funeral Director

à

Completed

Be

Funeral

Director

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any hjury or other traumatic event, I'm Madical Experiment must be notified at once.

Baltimore, Maryland 21215-0036

Physician/Medical

þ

physician the burial nas certificate filled in by

P.O.

State Registrar

Division of Vital Records, Completed Be 25. Was case referred to medical examiner? 1 ☐ Yes 2 ☐ No 27. Manner of Death Medical Certification: 1 Natural after death.

I Director: Air din by the fur 2 Accident 3 ☐ Suicide 4 Homicide To the Hospital within 24 hours a To the Funeral I completely filled 29a. Certifier 29b. Signature and title of certifier

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

and manner stated.

29d. Date signed (Month, Day, Year)

BAYUJEN AGAU EASTERN AUG BALTIMOR

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

Amend Item 23b per phys. G899 1/14/10 dk
State of Maryland / Department of Health and Mental Hygiene 1 - State Registra Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ 9:30 am December 2009 Nak Sun Kim Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death Frederick Kline Hospice Mount Airy 5. Social Security Number If Under 1 Year | If Under 24 Hrs Funeral 8. Date of Birth 9. Birthplace (State or Foreign Country) Korea 1 🛛 M 2 🗆 F Months Hours 0270471924 Director None 85 Usual Residence of Decedent ral", or items 23a or 28a-f show Examiner must be notified at 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director 1 Yes 2 No Maryland Frederick Frederick 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 3975 Triton Street 21704 Korea Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11 Marital Status 12. Was Decedent Ever in U.S. 14 Race - American Indian Armed Forces?

1 Yes 2 No Completed by 1 Never Married 2 Married 1 Yes If Yes, Give 1 ☐ Yes 2 X No Specify "natural", 3 X Widowed 4 Divorced Asian Year or Dates any injury or other traumatic event, the Medical 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business Industry (Specify only highest grade completed) and Mental Hygiene. Elementary/Seconday (0-12) College (1-4 or 5+) Business Owner Bookstore Be 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) should be filed and Mental H ပ Dong Won Kim Huun Muouna Cho 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Page 1 and 2 sh Department of Health ar Important: If item 27 is Seong Kim - Son 3975 Triton Street. Frederick. Maryland 21704 20a Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place 20c. Location - City or Town, State 1 X Burial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify) Norbeck Memorial Pk. 12/28/2009 Olney. Maryland 22. Name and Address of Facility Hines-Rinaldi Funeral Home, Signature of Funeral Service-Lis 11800 New Hampshire Ave.. Silver Spring. MD 20904 23a. Part 1. Enter the dise complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between Onset and Death shock, or heart failure. Lis ly one cause on each line Immediate Cause (Final Physician/ disease or condition resulting in death) Medical Due to (or as a consequence of): Examiner Sequentially list conditions, Examine if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Due to (or as a consequence of) that the death certificate be executed physician and the burial-transit that initiated events Due to (or as a consequence of) resulting in death) Last Physician/Medical attending pl IE EEMALE 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 - Ectopic pregnancy in the past 12 months? Dav Year 4 ☐ Pregnant at time of death g ☐ Unknown 5 Other (specify) 1 ☐ Yes Z **F** 9 ☐ Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ cate has been sig ; page 2 should b Completed 1 🗌 Yes 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an autopsy performed Yes 2 24 hours after death.

Funeral Director: After this certificate heted filled in by the funeral director, page 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 Residence 6 SOther (Specify) 2 No မ 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Hospice 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28c. Injury at work? 1 ☐ Yes 2 ☐ No 28b. Time of Certificate; 28d. Describe how injury occurred Hospital or Attending 1 Natural 5 Pending Accident Investigation 6 Could not be Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, Medical 29a. Certifier 🗵 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. To the Hosp within 24 hou To the Fune completed fi 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 29b. Signature and title of certifi 29d. Date signed (Month, Day, Year) 0063157 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) atel MD 31. Date filed (Month, Day, Year)

Registrar

State

Baltimore, Maryland 21215-0036

Box (

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Records,

Division of Vital

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) 3. Time of Death 11:55P Physician/ December 16 200°9" Waters Gerard Kurek Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death Anne Arundel Lothian 621 Traveller Court 9. Birthplace (State or Foreign Country) Maryland If Under 1 Year If Under 24 Hrs. 5. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth **Funeral** 1 🕅 M 2 🗆 F Months Hours 4/26/1952 **Director** Yrs 220-48-9180 Usual Residence of Decedent or 28a-f show notified at 10d. Inside City Limits . Page 1 and 2 should be filed within 72 hours after death with the Maryland ment of Health and Mental Hygiene. Hant: If item 27 is marked other than "natural", or items 23a or 28a-f shouly or other traumatic event, the Medical Examiner must be notified at jury or other traumatic event, the Medical Examiner must be notified at 10a. State 10b. County 10c. City, Town or Location Director 1 Tes 2 No Maryland Anne Arundel Lothian 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 621 Traveller Court 20711 USA Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11 Marital Status 12. Was Decedent Ever in U.S 14. Race - American Indian, Armed Forces?
1 X Yes 2 2 No 1974-1 Never Married 2 X Married Completed by Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify: Specify: White 1981 3 Divorced 4 Divorced Year or Dates 15 Decedent's Education 16a, Decedent's Usual Occupation (Give kind of work done during most of working life, DO NOT use retired) 16b. Kind of Business Industry (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) Certified Public Accountant Accounting Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ဂ္ Ellen Ross Daniel Adam Kurek 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 621 Traveller Court, Lothian, Maryland 20711 Isabel J. Kurek/Wife 20a. Method of Disposition 20b. Place of Disposition (Name of Date permit. Page 1 a
Department of H
Important: If ite
any injury or ott cemetery, crematory or other place) 1 ☐ Burial 2 🗓 Cremation 3 ☐ Removal from State 12/17/2009 Edgewater, Maryland Kalas Crematory 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility George P. Kalas Funeral Home 21. Signatur f Funeral Service Licensee a 2973 Solomons Island Rd. Edgewater, MD. 21037 23a. Part . Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Ph sician/ ROSTATE METASTATIC disease or condition) Medical resulting in death) Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examine Due to (or as a consequence of): To the Hospital or Attending Physician: The law requires that the death certificate be executed Cause (Disease or iinjury attending physician and for use as the burial-tran that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical Division of Vital Records, P.O. Box 68760 sate has been signed by the attending page 2 should be detached for use as IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?
1 ☐ Yes 2 ☐ No Day Year Month 5 Other (specify) 4 Pregnant
9 Unknown Pregnant at time of death Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an certificate 1 Yes 2 No Yes 2 No within 24 hours after death.

To the Funeral Director: After this certific completed filled in by the funeral director, 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 Amesidence 6 Other (Specify) Certificate: To 1 Tyes 2 210 1 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at work? 28d. Describe how injury occurred 1 Natural Accident injury 5 Pending 1 ☐ Yes 2 ☐ No Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Medical 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certifie 29c. License number 29d. Date signed (Month, Day, Year)

State

Registrar

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

WEIGER

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Registrar's Signature

JOH

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31. Date filed (Month, Day, Year)

26358

ORINCE

FREDERICK

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registra Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Kim Dect. 16,2009 Il Kon 2146 Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** c. County of Death
Montgomery Rockville Shady Grove Adventist 5. Social Security Number If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** Months Days 215-90-7814 1 🔀 M 2 🗆 F Hours Korea **Director** 74 Usual Residence of Decedent ir than "natural", or items 23a or 28a-f show the Medical Examiner must be notified at 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits with the Maryland Director Montgomery N.Potomac 1 ☐ Yes 2 No MD 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 20878 USA 12325 Mosel Terrace hours after death Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 12. Was Decedent Ever in U.S. 14. Race - American Indian Armed Forces?

1 Yes 2 No Black, White, etc. þ 1 Never Married 2 X Married Maryland 21215-0036 If Yes, Give Year or Dates 1 ☐ Yes 2 🔀 No Specify: Specify: Asian Completed 3 Widowed 4 Divorced 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) within 72 al Hygiene. General Maintenance Elementary/Seconday (0-12) College (1-4 or 5+) W.M.A.T.A. 12 Be permit. Page 1 and 2 should be filed Department of Health and Mental Hy Important: If item 27 is marked oth any injury or other traumatic event 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ပ Chang Jin Lee Sung Yong Kim 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Jong Ja Kim/Wife 12325 Mosel Terrace N.Potomac, Md 20878 Baltimore, 20a, Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State cemetery, crematory or other place)
Gate of Heaven 1 X Burial 2 🖊 Cremation 3 🗌 Removal from State 12/21/2009 Silver Spring, Md 4 Donatio 5 Other (Spec Signature uneral Service Li PANDER ADER PARTICE, P.A. 241 Columbia Blvd.Silver Spring,Md20910 23a. Part 1. Enter the disease, or complications that caused shock, or hear/failure. List only one cause on each line. disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between Onset and Death Immediate Cause (Final .Physician/ Renal Cell Carcinoma disease or condition resulting in death) Medical Due to (or as a consequence of) Examiner Sequentially list conditions. Examine if any, leading to immediate cause. Enter Underlying Due to (or as a consequence of) and I-transit The law requires that the death certificate be executed Cause (Disease or iinjury that initiated events resulting in death) Last Due to (or as a consequence of): attending physician for use as the burial Physician/Medical Division of Vital Records, P.O. Box 68760 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) in the past 12 months?
1 ☐ Yes 2 ☐ No Month Dav Year Pregnant at time of death Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 ☐ Yes 2 😾 No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of 24a. Was an has autopsy performed' death? 1 ☐ Yes 2 ☐ No _ Yes 25. Was case referred to medical To the Hospital or Attending Physician: 26. Place of Death (Check only one) Be Hospital: Other: 1 🔲 Yes 2 🔀 No မ 1 XInpatient 2 ☐ ER/Outpatient 3 ☐ DOA 4 Nursing Home 5 Residence 6 Other (Specify) After this 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred 1 XNatural 5 Pending Accident within 24 hours after death.

To the Funeral Director: Air completed filled in by the fu 1 ☐ Yes 2 ☐ No Investigation Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined City or Town, State) Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated (Check 3 🗆 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29b. Signature and title of Aertifier 29c. License number 29d. Date signed (Month. Day. Year) D62234 Dec.16,2009

Registrar

9707 Medical Center Drive Rockville, Md 20850

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

. Registrar's Sign

Manish Agrawal M.D.

31. Date filed (Month, Day, Year)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death **Physician** 2ďő9 Dec. Catherine Elizabeth Lang 1:40 P M /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death Examiner Washington 16505 Virginia Avenue #B104 Williamsport If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) Date of Birth (Month, Day, Year) Funeral Months Days Hours 1 □ M 2 N F 90 190-18-3758 Director 07/21/1919 OH Usual Residence of Decedent 10c. City. Town or Location 10a. State 10b. County 10d. Inside City Limits Item 27 is marked other than "natural", or items 23a or 28a-f show other traumatic event, the Medical Examiner must be notified at MD Washington Williamsport 1 ☐ Yes 2 No Director 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 16505 Virginia Avenue #B104 21795 US Funeral within 72 hours after death 12. Was Decedent Ever in U.S Armed Forces? 11. Marital Status Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black White etc. 1 ☐ Yes 2 🛣 No If Yes, Give Year or Dates: 1 XNever Married 2 Married White Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No þ Specify 3 ☐ Widowed 4 ☐ Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry College (1-4or 5+) Elementary/Secondary (0-12) Educator Education es 1 and 2 should be filed wi of Health and Mental Hygier fitem 27 is marked other th 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Catherine Elizabeth Schrock Chauncey Philip Lang 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Lynne F Moffitt, Niece 3324L Circle Brook Drive, Roanoke, VA 24018 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State Pages 1 permit. Pages 1 Department of H Important: If ite any Injury or ot 1 ☐ Burial 2 X Cremation 3 ☐ Removal from State Smithsburg Crematory 12/29/2009 Smithsburg, MD 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Gerald N. Minnich Funeral Home 305 N. Potomac Street, Hagerstown, MD 21740 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final Physician Due to was a consequence of): months resulting in death) Medical Examiner years aurtic stenosis Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) law requires that the death certificate be executed physician and s the burial-tran Due to (or as a consequence of): Division or Vital Records, P.O. Box 68760 Physician/Medical attending properties for use as IF FEMALE: 23c. If yes, outcome pf pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 □Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Year 4□Pregnant at time of death 5 ☐ Other (specify) 9 Unknown by signed to d be deta Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☐ No 24a. Was an autopsy page certificate To the Hospital or Attending Physician: 25. Was case referred to medical Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Living Hospital: 1 ☐ Inpatient 1 Yes 2 No 2 ER/Outpatient 3 DOA P After thi 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: 5 ☐ Pending investigation 1 Natural within 24 hours after death.

To the Funeral Director A completely filled in by the fu 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier (Check only one) 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) 29c. License number Cynthia Kuttner-Sands, MD D47451 December 28, 2009

Registrar DHMH 17 Rev 1/2001 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)
CYNTHIA KUTTNET-Sands, MD, Hospice of Washington County Hagerstown, Maryland

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

32. Registrar's Signature

31. Date filed (Month, Day, Year)

DEC 29 2009

747 Northern Avenue

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month / 2 Physician/ LINTON BETTY MARIE 07:14-PM Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death Washington County Hospital Hagerstown Washington If Under 1 Year If Under 24 Hrs. Social Security Number 9. Birthplace (State or Foreign Country) Maryland Funeral 7. Age (In vrs. last birthday) 8. Date of Birth (Month, Day,) 1 □ M 2 🎗 F Months Days **Director** 69 212-33-9489 Sept. Usual Residence of Decedent ral", or items 23a or 28a-f show Examiner must be notified at 10b. County 10a. State 10c. City, Town or Location 10d. Inside City Limits Director 1 X Yes 2 No Maryland Washington Hagerstown 10e Street and Number 10g. Citizen of What Country? Funeral 55 E. Washington Street 21740 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☒ No If Yes, Give Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian Completed by 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify: "natural", 3 Widowed 4 □ Divorced White Year or Dates any injury or other traumatic event, the Medical 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) al Hygiene. Elementary/Seconday (0-12) College (1-4 or 5+) Picture Frames <u>Assembler</u> Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) ပ Oscar Green Nettie May Dagenhart 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1 and 2 s of Health a item 27 i Sharon M. Linton - Daughter 1740 Edgewood Hill Circle #3, Hagerstown, MD 21740 20a Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State permit. Page 1 s Department of H Important: If ite 1 Burial 2 X Cremation 3 Removal from State 4 Donation 5 Other (Specify) Hagerstown Crematory 12/28/09 Hagerstown, Maryland 21. Signature of Funeral Service Licensee Minnich Funeral Home 22. Name and Address of Facility 415 E. Wilson Blvd. Hagerstown, Md. 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final Onset and Death Physician/ ATHEROSCLEROTIC Medical resulting in death) Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examine Due to (or as a consequence of) Cause (Disease or iinjury that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy 1 Live Birth 2 Fetal death 4 Pregnant at time of death 9 Unknown 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy 5 Other (specify) ____ in the past 12 months? 1 ☐ Yes 2 ☐ No 9 Unknown P.0. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ FAILURE Records, 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an 1 Yes 2 No Yes 25. Was case referred to medical **Division of Vital** Be 26. Place of Death (Check only one) examiner? Other: ည 1 Inpatient 2 ER/Outpatient 3 IDOA 4 Nursing Home 5 Residence 6 Other (Specify) this 28b. Time of 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28c. Injury at Certificate: 28d. Describe how injury occurred To the Hospital or Attending 1 Natural injury 5 Pending work? 1 ☐ Yes 2 ☐ No s after death. Director: Aft d in by the fur 2 Accident 3 Suicide Investigation 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, completed filled in by 4 Homicide determined Medical 29a. Certifier Decrtifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

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Registrar

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KRISHNAMOORTHY

30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 11110 MEDICAL

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

00061411

HAGERSTOWN

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death Reg. No. 2 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ December 27, 2009 Alan LUEHRMANN 4:00 A M Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death Examiner 4c. County of Death 2400 Parker Avenue Silver Spring Montgomery . Social Security Number If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Ye. Feb. 16 9. Birthplace (State or Foreign Country) Ohio **Funeral** 6. Sex. 1 M M 2 □ F 7. Age (In yrs. last birthday) 577-44-3425 76 Director 1′933 Usual Residence of Decedent 28a-f shov 10b. County 10a. State 10c. City, Town or Location must be notified at 10d. Inside City Limits Funeral Director 1 Yes 2 X No Silver Spring Maryland Montgomery 10e. Street and Number 10g. Citizen of What Country? 23a United States 20902 2400 Parker Avenue 12. Was Decedent Ever in U.S. Armed Forces? 1 Yes 2 No Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14 Race - American Indian Black, White, etc. Completed by 1 Never Married 2 X Married 1 Yes If Yes, Give Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify: "natural", 3 Widowed 4 Divorced Year or Dates injury or other traumatic event, the Medical 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) Federa1 College (1-4 or 5+) 5+ Elementary/Seconday (0-12) Chemical Engineer Government Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ဂ Grace Doldt Edward Luehrman 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 2400 Parker Avenue, Silver Spring, MD 20902 permit. Page 1 and 2 sh Department of Health ar Important: If item 27 is any injury or other trau Phyllis Dobin, Wife 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date 1 XBurial 2 Cremation 3 X Removal from State 4 Donation 5 DOther (Specify) National Memorial Park 12/27/09 Falls Church, VA . Signature of truenal Service Licenses 01003 22. Name and Address of Facility Torchinsky Hebrew Funeral Home Position of the disease, or complications that caused the death. Do not only the many figures of the disease, or cardinor respiratory areas shock, or heart failure. List only one cause on each line. 2001 2 Approximate Interval Between Immediate Cause (Final disease or condition Metastatic Prostate Cancer 0 Years Physician/ Medical resulting in death) Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examine Due to (or as a consequence of) attending physician and for use as the burial-transit Cause (Disease or iinjury that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregris 5 ☐ Other (specify) Ectopic pregnancy in the past 12 months? Month Year Pregnant at time of death Unknown g 🗌 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 9 Division of Vital Records, 1 ☐ Yes 2 🕅 No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an autonsy Yes 2 X No within 24 hours after death.

To the Funeral Director, After this certific.
completed filled in by the funeral director, To Be 25. Was case referred to medical 26. Place of Death (Check only one) Other: 1 ☐ Yes 2 💢 No 4 Nursing Home 5 Residence 6 Other (Specify) 1 Inpatient 2 ER/Outpatient 3 DOA 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28c. Injury at Certificate: 28b. Time of 28d. Describe how injury occurred To the Hospital or Attending 1 XNatural 5 Pending injury 1 ☐ Yes 2 ☐ No Accident Suicide Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined City or Town, State) Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. (Check Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated

Box 68760

P.O. I

Registrar DHMH 17 Rev 7/2009

State

29b. Signatur

31. Date filed (Month, Day, Year)

DEC 23

title of certifie

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Ram Trehan, M.D., 1400 Forest Glen Road, Suite 435, Silver Spring, MD

32. Registrar's Signature

3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29c. License number

D 33224

29d. Date signed (Month, Day, Year) December 21, 2009

20910

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2 Date of Death 3. Time of Death Physician/ 11:00 pm 2009 December Lucerne Luna Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death Examiner 4c. County of Death Lanham Prince George's Tate House 5. Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 6 Sex 8, Date of Birth 9. Birthplace (State or Foreign **Funeral** Country) Illinois 1 🗆 M 2 🗓 F Months Days Hours 09 729 / 1926 Director 83 218-20-0426 Usual Residence of Decedent "natural", or items 23a or 28a-f show dical Examiner must be notified at 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director 1 X Yes 2 No Lanham Maryland Prince George's 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral with 20706 9885 Greenbelt Road. U.S.A. within 72 hours after death 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 11. Marital Status 14. Race - American Indian, Armed Forces Black, White, etc. þ 1 Never Married 2 Married ☐ Yes 2 X No Baltimore, Maryland 21215-0036 If Yes, Give Year or Dates 1 ☐ Yes 2 🗓 No Specify: Specify White Completed 3 X Widowed 4 ☐ Divorced the Medical 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working Page 1 and 2 should be filed within 72 ment of Health and Mental Hygiene. tant: If item 27 is marked other than 'iury or other traumatic event, the Me life. DO NOT use retired) College (1-4 or 5+) **5+** Elementary/Seconday (0-12) University of Maryland Secretary Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ပ Frances Violet Cross Thomas William Holmes 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 4804 Lackawanna Street, College Park, MD 20740 Thomas L. Redd - Son permit. Page 1 and 2 Department of Healt Important: If item 2 any injury or other 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Lincoln Cemetery 12/23/2009 Brentwood, Maryland 21. Signature of Funeral Service Licenses 22. Name and Address of Facility Hines-Rinaldi Funeral Home. Inc. 11800 New Hampshire Ave., Silver Spring. MD 20904 folications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, cause on each line. 23a. Part 1. Enter the disease, of shock, or heart failure. List on Approximate Interval Between Onset and Death 5 **Lears** Immediate Cause (Final Physician, Parkinson's Disease disease or condition Medical resulting in death) Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Examine Due to for sels consequence on Hospital or Attending Physician: The law requires that the death certificate be executed use as the burial-transit that initiated events Due to (or as a consequence of): resulting in death) Last nding physician Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE yes, outcome of pregnancy
Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?
1 \(\subseteq \) Yes 2 \(\subseteq \) No for 5 Other (specify) Month Dav Year Pregnant at time of death ate has been signed by the a page 2 should be detached it Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Completed 1 ☐ Yes 2 X No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of autopsy performed? Yes 2 death? certificate 1 Yes completed filled in by the funeral director, 25. Was case referred to medica Be 26. Place of Death (Check only one) examiner? Other: 2 X No. မ 1 Inpatient 2 ER/Outpatient 3 DOA 4 □ Nursing Home 5 □ Residence 6 ₺ Other (Specify) Hospice After this 28b. Time of 27. Manner of Death 28a. Date of injury (Month, Day, Year) Certificate: 28c. Injury at 28d. Describe how injury occurred 1 X Natural injury work? 1 ☐ Yes 2 ☐ No 5 Pending s after death. М Accident Investigation 6 Could not be Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number. 4 Homicide determined To the Hospital of within 24 hours a To the Funeral D 🗷 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b, Signature and title of certifie 29c. License numbe 29d. Date signed (Month, Day, Year) D26287 December 23, 2009 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Michael Berard M.D 7305 Baltimore Avenue, Suite 107, College Park, MD 20740

State

Registrar

31. Date filed (Month, Day, Year)

23

Registrar's Signature

Division of Vital Records, P.O. Box 68760, To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

MAX	(First, Mida	de last)		Ce	rtificate of	Death	2. Date of Dea	Reg. No. 20	09	L 283		
				LOU	JTZKER		December 1	er 19, 2	009	5:30P. N		
a. Facility Name (II Bedford		on, give street and n	umber)			r Location of Death Spring		4c. County o	^{f Death} tgomer	V		
Social Security No 065-09-48	umber	6. Sex 1 X M 2□ F	7. Age (In yrs.	last birthday) 5 Yrs.	1	If Under 24 Hrs. Hours Min.	8. Date of Birth			(State or Forei		
sual Residence of Da. State	Decedent 10b. County	V	10c Cit	v. Town or Lo	ocation				10d J	nside City Limit		
Maryland		gomery			Spring			1 🗆				
De. Street and Nun		onal Driv	e		10f. Zip Code 20906			10g. Citizen of What Country? United States				
Marital Status □ Never Marrie X Widowed		rried Armed I			Was Decedent of H If Yes, specify Cubin 1 □ Yes 2X No	Hispanic Origin? (Sp an, Mexican, Puerto Specify:	pecify Yes or No- Rican, etc.)	14. Race Black Specify:	- American II , White, etc. Whit			
	ify only highe	nt's Education est grade completed	1)	(Give	edent's Usual Occup e kind of work done DO NOT use retired	during most of work	ting	16b. Kind of Bus	iness/Industr	у		
Elementary/Secon	12 12	College	(1-4or 5+)	l .	Turner			Manufac	turing			
7. Father's Name (Hersch Lo u		, Last)				18. Mother's Nam Hinda F	e (First, Middle, olkowit:)			
9a. Informant's Na Cam Schmi	me/Relation:	ship <i>(Type. Print)</i> on in law		19b. Maili 5505	ng Address <i>(Street</i> Parkston	and Number or Ru Road Bet	hesda, Numbe	r, City or Town, S Maryland	State, Zip Cod 20816	ie)		
0a. Method of Disp 1∕⊾ Burial 2 ☐ 4 ☐ Donation	Cremation	3 Removal from	n State We1	Place of Disponentery, creations of the contract of the contra	osition (Name of matory or other plac Cemetery	^{ce)} 12/28/	Date 2009	20c. Location - C	•			
1. Signature of Fu			and all			Borgward r Mill Ro		0	,			
sequentially list con any, leading to imi ause. Enter Under ause (Disease or nat initiated events esulting in death) L	injury	S c	o (or as a conseq									
		u										
F FEMALE: 3b. Was decedent in the past 12 if yes 2 from 9 Unknown	months?	1 Live	utcome of pregna e birth 2 ☐ Feta egnant at time of c known	death 3	☐ Ectopic pregnand ☐ Other (specify) _	Sy		23d. Date Mon	of delivery th Day	Year		
3b. Was decedent in the past 12 i 1 ☐ Yes 2 ☐ 9 ☐ Unknown	months? No icant conditi	1 ☐ Live 4 ☐ Pre	e birth 2 Feta egnant at time of d known	Ideath 3[leath 5[Other (specify)	,		Mon	th Day	ause of death?		
3b. Was decedent in the past 12 i 1 ☐ Yes 2 ☐ 9 ☐ Unknown art II. Other signifi	months? No icant conditi	1 Liv 4 Pre 9 Unl	e birth 2 Feta egnant at time of d known	Ideath 3[leath 5[Other (specify)	,	1 □ Y	monophacco use contributes 2 X No 3 an 24b. Wasy professor	bute to the ca	ause of death? 4 Unknow findings availabition of cause o		
3b. Was decedent in the past 12: 1 Yes 2 9 Unknown art II. Other signification of the period o	months?] No icant conditi	1 Livi 4 Pre 9 Uni ions contributing to	e birth 2 Feta egnant at time of d known	Ideath 3[leath 5[☐ Other (specify) _	en in Part I. 26. Place of Dea	1 □ Y 24a. Was a autop perfor 1 □ Yes	Monobacco use contritues 2 X No 3 an 24b. Who sy med? 2 X No 1	th Day bute to the ca B Probably ere autopsy ior to comple sattn? Yes 2	ause of death? 4 ☐ Unknow findings availabition of cause of		
3b. Was decedent in the past 12: 1 Yes 2 9 Unknown art II. Other signification of the past of th	months? No ed to medica	ions contributing to Hospital: 28a. Dat	e birth 2 Feta gnant at time of c known death but not resi	I death 3 [leath 5 [ulting in the u ER/Outpatie 28b. Time c	□ Other (specify) _ underlying cause giv	en in Part I. 26. Place of Dear ef: 4 \(\) Nursing He	1 Y 24a. Was a autop performance to Check only or one 5 Residence to Residence t	obacco use contritues 2 X No 3 an 24b. Wasy properly of 2 X No 11	th Day bute to the ca B Probably ere autopsy ior to comple path? Pes 2X	ause of death? 4 ☐ Unknow findings availabition of cause of		
3b. Was decedent in the past 12: 1 Yes 2 9 Unknown art II. Other signification of the period o	ed to medica	ions contributing to Hospital: 1 28a. Dat (Motigation Inot be proper limited)	e birth 2 Feta gnant at time of c known death but not resi Inpatient 2 e of Injury onth, Day, Year)	ER/Outpatie 28b. Time c Injury	Other (specify) underlying cause giv nt 3 □ DOA Oth of 28c. Injur Wor	en in Part I. 26. Place of Dear ef: 4 \(\) Nursing He	1 Y 24a. Was a autop performence of Check only or ome 5 Reside 28d. Describe h	Mon bacco use contrit es 2 X No 3 an 24b. W pr med? de 2 No 1 ne) lence 6 X Other ow injury occurrent treet and Numbe.	th Day bute to the ca B Probably fere autopsy- ior to comple sath? Yes 2X TASESINS	ause of death? 4 Unknow findings availab tion of cause o		
3b. Was decedent in the past 12: 1 Yes 2 9 Unknown art II. Other signiff Dementia 5. Was case referr examiner? 1 Yes 2 Manner of Death 14 Natural 2 Accident 3 Suicide 4 Homicide	ed to medical No 5 Pendin invest 6 Could deterr	al Hospital: Inguing Physician: To the Examiner: On the	e birth 2 Feta reginant at time of content at time	ER/Outpatie 28b. Time of Injury me, farm, stry)	Other (specify) Inderlying cause give Int 3 DOA Other Other A 28c. Injury Wor M 1 DOA reet, factory, office	26. Place of Dealer: 4 Nursing Hryat k? Yes 2 No	1 Y 24a. Was a autop perfor 1 Yes th (Check only or ome 5 Resid 28d. Describe h 28f. Location (S City or Tow	Mon bbacco use contrit es 2 No 3 an 24b. W pr meg? 2 No 1 ence 6 Nother ow injury occurrence treet and Number m, State)	th Day bute to the ca B Probably ere autopsy ior to comple sath? Yes 2X r Assin S d	ause of death? 4 Unknow findings availabtion of cause of No ted Liv ute Number,		
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Stat Registra

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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. amend #17,18619a Per FH C917/711/2011 Jh

		For State Registrar	State of Marylar		rtment of F tificate of			jiene eg. No.2 N	09 62838		
Physic /Med		1. Decedent's Name (First, Middle, Sonia L.	Lope z				2. Date of Dea Dec . 21	, 2009	Year 3. Time of Death 8:50a M		
Exam		4a. Facility Name (If not institution,	·		-	Location of Death		4c. County o	of Death gomery		
Funera Directo		Casey House 5. Social Security Number 213-51-6149	6. Sex 7. Age (In yrs. 1		If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day 2 / 08 /		Birthplace (State or Foreign Country) Chile		
Maryland f show	tor	Usual Residence of Decedent 10a. State 10b. County MD Montg		ty, Town or Loc	ation ersburg				10d. Inside City Limits 1 □ Yes 2 🎗 No		
h with the I 23a or 28a at be notif	Funeral Director	10e. Street and Number 28 Steven Co	urt		10f. Zip Code 208	77	1	0g. Citizen of WI	hat Country?		
d 21215-0036 filed within 72 hours after death with the Maryland Hygiene. Wher than "natural", or items 23a or 28a-f show ant, it is Medical Examinar must be notified at	þ	11. Marital Status 1 □ Never Married 2 ☑ Marrie 3 □ Widowed 4 □ Divorced	12. Was Decedent Ever in U. Armed Forces? 1 _Yes 2 _No If Yes, Give Year or Dates:	If	/as Decedent of H Yes, specify Cuba	ispanic Origin? (Sp in, Mexican, Puerto Specify: Chi		Black	American Indian, White, etc.		
Baltimore, Maryland 21215-0036 sermit. Pages 1 and 2 should be filed within 72 hours afti Department of Health and Mental Hygene. mportant: If item 27 is marked other than "natural", or in yinury or other traumatic event, Its Modest Exercity in the content than "natural".	Completed	15. Decedent's (Specify only highest Elementary/Secondary (0-12) 1 2	s Education grade completed) College (1-4or 5+)		ent's Usual Occup ind of work done o O NOT use retired nemaker	ation during most of work)	ing	16b. Kind of Bus	siness/Industry Home		
yland; buld be filed Mental Hyg arked other	To Be C	17. Father's Name (First, Middle, L Luis Aiberto Lop Andres Lopez	ez-Arteaga				Velasquez Velasquez				
s 1 and 2 sho of Health and item 27 is m		Victor Olmos/Hu	Husban d	28 St	teven C		ithersb	urg,Md	20877		
Baltimore, permit. Pages 1 ar Department of Hea Important: If item any injury or otherone.	1	20a. Method of Disposition 1 ☑ Burial 2 ☑ Cremation 3 4 ☐ Donation 5 ☐ Other (Sp.	egity A	ll Sou	ition (Name of atory or other plac uls Cem	. 12/23	3/2009	Germa	or Town, State		
Balt permit. Depart Import any inj		21. Signature of Funeral Service	all	94	24! COL	umbia B.	Lvd.Sil	ver Sp	VICE, P.A. ring, Md20910		
Physician /Medical		23a. Part1. Inter le disease, or c shock, or he rt failure. List o Immediate Cause (Final disease or condition resulting in death)	a_ Metastat	ic gal				est,	Approximate Interval Between Onset and Death		
68760, ifficate be executed g physician and as the burial-transit	edical Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter underlying Cause (Disease or injury that initiated events resulting in death) Last	b. Due to (or as a consequence of the consequence o	uence of):							
Box eath cert attending for use a	Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 ▼No 9 □ Unknown	23c. If yes, outcome of pregna 1 ☐ Live birth 2 ☐ Feta 4 ☐ Pregnant at time of d 9 ☐ Unknown	Ideath 3 🗌	Ectopic pregnancy Other (specify)			23d. Date Mont	of delivery . th Day Year		
Records, P.O. e law requires that the d has been signed by the e 2 should be detached		Part II. Other significant condition	s contributing to death but not resu	ulting in the und	derlying cause give	n in Part I.			bute to the cause of death? 3 Probably 4 Unknown		
of Vital Records, Physician: The law requires the this certificate has been signer rall director, page 2 should be of	Completed by	25. Was case referred to medical					24a. Was ai autops perforn 1 □ Yes 2	y pri ned? de 2 X No 1 [dere autopsy findings available rior to completion of cause of eath? □Yes 2 □No		
Division of Vital Re To the Hospital or Attending Physician: The I within 24 hours after death. To the Funeral Director: After this certificate he completely filled in by the funeral director, page	Certification: To Be	examiner? 1 Yes 2 No 27. Manner of Death 1 Natural 5 Pending 2 Accident investiga 3 Suicide 6 Could no	t he	28b. Time of Injury	28c. Injury Work M 1 🗆 Y	4 ☐ Nursing Ho		nce 6XIOther	r (Specify)hospice		
Divi		4 ☐ Homicide determin	building, etc. (Specify	/)			City or Town	, State)	r or Rural Route Number,		
the Hos in 24 ht he Fun- ipletely	Medical	(Check only one)	Physician: To the best of my know caminer: On the basis of examination and manner stated.	tion and/or inve	estigation, in my op	ie, date and place, pinion, death occurr	and due to the cared at the time, da	ause(s) and man ate and place, an	ner as stated. nd due to the cause(s)		
To t within	Ž	29b. Signature and title of certifier J. KD U.O.	tehou, m	15	29c. License	number 748	2!	Dec . 21	(Month, Day, Year)		
		30. Name and address of person what Jocelyne Kot	udtchou M.D.	6001	*	er Mill	Rd Ro	ckville	e,Md 20855		
Sta Regist		31. Date filed (Month, Day, Year)	32 Registrar's Signat	ban ban	Les.						

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death **Physician** Betty Louise Mathias December 16 2009 8:07 a M /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner Westminster Carroll Golden Living Center f Under 1 Year | If Under 24 Hrs. 5. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** Days 1 M 2 TF 212-24-3589 Director 81 Oct 10 1928 MD Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10a. State 23a or 28a-f show other traumatic event, the "Indical Examinary ust be notified at 1 ☐ Yes 2 ☑ No Funeral Director MD Carroll Westminster 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number 797 Scotsdale Ct. 21157 USA 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) or items 14. Race - American Indian, 11. Marital Status Black, White, etc. Pages 1 and 2 should be filed within 72 hours after r ment of Health and Mental Hygiene. ant: If item 27 is marked other than "natural", or ite 1 ☐ Yes 2 ☑ If Yes, Give Year or Dates: 2 X No 1 ☐ Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2X No Specify ģ Specify: White 3 Widowed 4 □ Divorced Be Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Manager American Legion 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Raymond Geisbert ပ Clara Reed 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Terry Mathias/daughter 797 Scotsdale Ct., Westminster, MD 21157 Department of Healt Important: If item 2' any injury or other once. 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition Burial 2 Cremation 3 Removal from State Mt. Olivet Cemetery 12/19/2009 Frederick, MD 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee Printer Time fadily Home and Chapel, P.A. lask 412 Washington Road Westminster, MD 21157 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** disease or condition resulting in death) /Medical Due to (or as a consequence of): **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to (or as a consequence of) Physician: The law requires that the death certificate be executed Due to (or as a consequence of): Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☑ No Month Year Day 5 ☐ Other (specify) 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Division of Vital Records, ģ 1 ☐ Yes 2 No 3 ☐ Probably 4 ☐ Unknown Be Completed funeral director, page 2 should 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? Yes 2 1 ☐ Yes 2 No 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To 28a. Date of Injury (Month, Day, Year) 28c. Injury at Work? 27. Manner of Death 28d. Describe how injury occurred or Attending 1 Natural 5 Pending To the Hospital or Attendir within 24 hours after death.
To the Funeral Director: A completely filled in by the fu 1 ☐Yes 2 ☐ No investigation 2 Accident 3 Suicide 6 ☐ Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide 12 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical (Check only 29b. Signarde and title of certifier 29c. License number 29d. Date signed (Month, Day, Year)

MJL 2

Box 68760.

P.O.

State Registrar

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death ^{Day}2009 **Physician** 23, Dec. Markow Ruth D. /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death **Examiner** Ceci1 Calvert Manor Nursing Home Rising Sun If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, 9. Birthplace (State or Foreign Social Security Number 6. Sex 7. Age (In yrs. last birthday) **Funeral** 222-44-5053 Months Days Hours 1 M 2 X F Wilmington, DE Director Oct.6,1911 98 Usual Residence of Decedent permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, if a Neulcel Exandratic be multified at once. 10d. Inside City Limits 10a, State 10b. County 10c. City, Town or Location Earleville 1 ☐ Yes 2 No Ceci1 MD Directo 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number USA 21919 197 Clemencia Road Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ∐Yes 2 ŒNo If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 11. Marital Status 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 □Yes 2 □No à Specify. white Specify: 3 X Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) own home homemaker 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Anna Carter James DuBois ဥ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 197 Clemencia Rd. Earleville, MD 21919 Deborah L. Connell (great-Niece) 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition Date 1 ☐ Burial 2 X Cremation 3 ☐ Removal from State Dec.28,2009 Wilmington, DE McCrery Crematory 4 □ Donation 5 □ Other (Specify) 22. Name and Address of Facility McCrery Funeral Homes, Inc. 3924 Concord Pike 21. Signature of Funeral Service Licensee MOD Wilmington, DE Approximate Interval Between Onset and Death 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) **Physician** 0 /Medical Due to (or a a consequence of): Examiner Marc Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner Hospital or Attending Physician: The law requires that the death certificate be executed attending physician and for use as the burial-trar Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months 1 ☐ Yes 2 ☐ № Month Year Day 4 ☐ Pregnant at time of death 5 Other (specify) 9 ☐ Unknown 9 Unknown signed I d be det 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. þ 1 ☐ Yes 2 LIMO 3 ☐ Probably 4 ☐ Unknown ter this certificate has been s neral director, page 2 should Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed 1 ☐ Yes 2 ☐ No 1 □Yes 2 14No 25. Was case referred to medical examiner? 26. Place of Death (Check only one, Be Other: 4 Vursing Home 5 Residence 6 Other (Specify) 1 Inpatient 2 ER/Outpatient 3 DOA Certification: To 28a. Date of Injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28d. Describe how injury occurred After t funera 28c. Injury at Work? 5 ☐ Pending investigation 1 Natural Injury 1 ☐ Yes 2 ☐ No 2 Accident after death Director: 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 29a. Certifier 1 🖫 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only

Ivision of Vital Records, P.O. Box 68760 n 24 hours after le Funeral Dire pletely filled in b completely within 2.

> State Registrar

one)

31. Date filed (Mg

29b. Signature and title of certifier

Day, Year)

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

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-MI)

82. Registrar's Signature

EL

29c. License number

29d. Date signed (Month, Day, Year)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

			For State	State o	of Marylan					and M		-		
			1 - State Registrar Certificate of Death Reg. 1. Decedent's Name (First, Middle, Last) 2. Date of Death									Reg. No. 2	109	3 finterof Beath
	Physici	an								,	Month	Day	Year	1:30 A ^M
4	/Medio	- 3	Mary Ellen 4a. Facility Name (If not institution	Morrison	(mbar)		4b City T	OWn or	Location o		Decembe	4c. Count	2009	1:30 A
	Examir	er	Homewood at				, ,		rick	Death			reder	-ick
	Funcial		5. Social Security Number	6. Sex	7. Age (In yrs.	last birthday)	If Under	1 Year	If Under 2		8. Date of Birt	h	9. Birtho	lace (State or Foreign
н	Funeral Director		135-12-5952	1 □ M 2 X □ F	94	Yrs.	Months	Days	Hours	Min.	in. (Month, Day, Year) Country) June 15,1915 Illinoi			try)
2,000	and the second s		Usual Residence of Decedent									,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,		
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36	s afte or it	by Fi	1 Never Married 2 Mar	If Yes, G			1 Yes 2	No	Specify:			Specia	y:	
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an	d be ental ced o	o Be		acobs					U	nkno	wn St	raughn		
<u> </u>	12 should be filed w n and Mental Hygie is marked other ti raumatic event, th	ဥ	19a. Informant's Name/Relation			19b. Mailii	ng Address	(Street a				er, City or Town	. State. Zip	Code)
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	ges 1 and 2 should be filed within 72 hours after death with the Marylar tof Health and Mental Hygiene. If item 27 is marked other than "natural", or items 23a or 28a-f show or other traumatic event, the Medical Examiner must be notifiled at		20a. Method of Disposition	<u> </u>	20b. F	Place of Dispo	sition (Nam	e of	->	D	ate	20c. Location	- City or To	wn, State
Baltimore,			1 ☐ Burial 2 ☐ Cremation 4 ☐ Donation 5 ☐ Other (3 Removal from	i State	cemetery, cre auffer	-		· i	12/1	7/2009	Frede	rick.	, Maryland
∄	permit. Pa Departmer Important: any injury		21. Signature of Funeral Service				2. Name and			-		Funera	-	•
21. Signayore of Funeral Service Licensee 22. Name and Address of Facility 1621 Opossumto								-						
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8			23a Par 1. Enter the diserse, of lock, or heart failure. Lis	t only one cause 🦛	each line.	2 1				0	1	-		Interval Between Onset and Death
\hat{I}	Physician /Medical		disease or condition resulting in death)	a	(or as a cons-c	U)	mo	28	14	+	5105	()		YLARS
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	w requires that the s been signed by the should be detache		Part II. Other significant condit	ions contributing to	death but not res	sulting in the u	nderlying ca	use give	en in Part I.		23e. Did t	obacco use cor	tribute to th	ne cause of death?
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	To the Hospital or Attending Physwithin 24 hours after death. To the Funeral Director: After this completely filled in by the funeral di	<u> </u>		ng Physician: To th										
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	2		30. Name and address of person	/						_			1	
_	9		Casper Cline,		0 West		reet,	Fre	deric	k, M	D 2170	L		
	Sta	ite	31. Date filed (Month, Day, Year	Q 2000 32.	Registrar's Sign	ature	boule	,						

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Please Type or Print in Black Indelible Ink, Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Month 13:59 PM Decembe Evelyn Mary MCCARREN Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death Washington County Hospital Washington Hagerstown 5. Social Security Number 8. Date of Birth (Month, Day, Year 7. Age (In vrs. last birthday) 9. Birthplace (State or Foreign **Funeral** 1 □ M 2 🗓 F Months Davs Hours Min Director 93 166-01-1459 Oct 1916 <u>Pennsylvania</u> Usual Residence of Decedent "natural", or items 23a or 28a-f show edical Examiner must be notified at Page 1 and 2 should be filed within 72 hours after death with the Maryland ment of Health and Mental Hygiene.

ant: If item 27 is marked other than "natural", or items 23a or 28a-f show 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director 1 Yes 2 No Maryland Washington Hagerstown 10e. Street and Number 10f. Zip Code 10g, Citizen of What Country? Funeral 55 E. Washington Street 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☒ No 11. Marital Status 13. Was Decedent of Hispanic Origin? (Specify Yes or No-14. Race - American Indian If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 0 Black, White, etc. Completed by 1 Never Married 2 Married 3altimore, Maryland 21215-0036 1 ☐ Yes 2 🕅 No Specify: If Yes, Give Specify White 3 X Widowed 4 Divorced Year or Dates marked other than "natur matic event, the Medical 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b Kind of Business Industry (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) n Dress Mfg Seamstress 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) William College Mary Hammil 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Patrick McCarren -Son 10006 Pleasant View Drive, Hagerstown, Md. 21740 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Date = 6 1 X Burial 2 Cremation 3 Removal from State Important: If any injury or 4 ☐ Donation 5 ☐ Other (Specify) Rest Haven Cemetery 12/30/09 Hagerstown, Maryland 21. Signature of Funeral Service License 22. Name and Address of Facility Minnich Funeral Home 415 Wilson Blvd. Hagerstown, Md. 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between shock, or heart failure. List only one cause on each line Immediate Cause (Final Onset and Death Physician disease or condition resulting in death) Ongres Medical Due to (as a consequence of): Examiner Sequentially list conditions. Examine if any, leading to immediate cause. Enter Underlying r as a consequence of) or Attending Physician: The law requires that the death certificate be executed Cause (Disease or iinium the burial-tran that initiated events resulting in death) Last Due to (or as a consequence of): physician Physician/Medical Division of Vital Records, P.O. Box 68760 use as attending IF FEMALE 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery Ectopic pregnancy in the past 12 months?

1 Yes 2 No
9 Unknown for Month Pregnant at time of death 5 Other (specify) Day Year the detached 9 Unknown signed by t Id be detach Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 Yes 2 No 3 Probably 4 Unknown completed filled in by the funeral director, page 2 should been 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an certificate has autopsy performed? Yes 2 No 1 ☐ Yes 2 ☐ No æ 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 2 X No 은 1 ☐ Inpatient 2 🛛 ER/Outpatient 3 ☐ DOA After this 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred work? Natural iniury 5 Pending s after death Accident Suicide Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number. 4 Homicide City or Town, State) within 24 hours a To the Funeral L Medical 29a. Certifier 🗠 Pritifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 3 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year)

State Registrar COURT

OPAL

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

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ascem

31. Date filed (Month, Day, Year)

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Hagerstown Maryland

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month **Physician** Day Year 40 Mamela /Medical 4a. Facility Name (If not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death 5. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Ye 11/5/1937 9. Birthplace (State or Foreign **Funeral** 1 □ M 2X F Months Days Hours Min Director 72 020-30-4322 Usual Residence of Decedent permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If then 27 is marked other than "natural" Action other than any injury or other than 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director 1 ☐ Yes 2 X No MD Kent Chestertown 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? by Funeral 7337 Wilkins Lane 21620 USA 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 22 No Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Black, White, etc. 1 ☐ Yes 24☐ If Yes, Give Year or Dates: 1 Never Married 2 Married 1 □ Yes 2 No Specify: Specify: White 3 Widowed 4 Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) 12 Artist Arts 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Sanford Parker Virginia Hubbard ဂ္ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Louis G. Michael/husband 7337 Wilkins Lane, Chestertown, MD 21620 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 □ Donation 5 □ Other (Specify) Chesapeake Cremation 12/14/2009 Stevensville, MD 21. Signature of Funeral Service Licens 22. Name and Address of Facility. Fellows, Helfenbein & Newnam Funeral Home 130 Speer Rd. Chestertown, MD 21620 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** rneymonia /Medical Due to (or as a consequence of): **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner Hospital or Attending Physician: The law requires that the death certificate be executed and Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, attending physician Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 23b. Was decedent pregnant 23d. Date of delivery Live birth 2 Fetal death 3 Ectopic pregnancy in the past 12 months? Month Year Day 4 Pregnant at time of death 5 Other (specify) the 9 Unknown signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Vunknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has autopsy certificate performe 2 No 2 No 1 □ Yes 1 ☐ Yes 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Certification: To 1 Yes 2 No 1 🕅 Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA After this Date of Injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 1 Matural 5 Pending I Director: / investigation 1 ☐ Yes 2 Accident 2 No 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide n 24 hou، the Funeral Dire مال filled in 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. cal 29a. Certifier (Check only one) within 2 To the I the 29b. Signature and title of certifier ٥ 29c. License number D 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) mo Mun evin Baltmake, . Z. 31. Date filed (Month, Day, Year) 32. Registrar's Signature State Registrar

DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Year **Physician** 42009 RANCES CATHERINE MCGINNIS DECEMBER /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner CHESTER HOSPITAL CENTER CHESTER TOWN

7. Age (In vrs. last birthday) If Under Tyear If Under 24 Hrs. 8. Date of KENT RIVER Birthplace (State or Foreign Country) Social Security Number 8. Date of Birth (Month, Day, Year) **Funeral** Months Days Min. 1 □ M 2X F Director 215-26-4830 6/16/1912 MDUsual Residence of Decedent death with the Maryland 10d. Inside City Limits 10a. State 10b. County 10c. City, Town or Location ir than "natural", or items 23a or 28a-f show the Medical Examiner must be notified at MD Sudlersville Queen Anne's 1 ☐ Yes 2X No Director 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 5500 Sudlersville Rd. 21668 USA Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 █ No Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. Black, White, etc. Pages 1 and 2 should be filed within 72 hours after nent of Health and Mental Hygiene. ant: If item 27 is marked other than "natural", or ite 1 ☐ Yes 2 ☑ If Yes, Give Year or Dates: 1 Never Married 2 Married ٥ Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify Specify: White þ 3 → Widowed 4 □ Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Repair Department Travelwear 7 is marked other traumatic event, II 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Watson Clough Ella Jackson ဂ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Watson Clough/Nephew 250 Mussina Rd. Dover, DE 19904 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State Department of Important: If it any Injury or o once. 1 N Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Templeville Cemetery: 12/10/09 Templeville, MD 22. Name and Address of Eacility
Fellows, Helfenbein & Newnam Funeral Home
370 W. Cypress St. Millington, MD 21651 21. Signature of Funeral Service Licensee Hari 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** /Medical Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to (or as a consequence of): Hospital or AttendIng Physician: The law requires that the death certificate be executed physician and is the burial-trans Due to (or as a consequence of): O. Box 68760, Physician/Medical attending p IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Month Day Year 5 Other (specify) this certificate has been signed by the ral director, page 2 should be detached 9 Unknown 9 Unknown ۵. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, 2 2 No 3 Probably 4 Unknown 1 Tes Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy perform 1 ☐ Yes After this certification funeral director, p 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Be 1 Yes ♣ No Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 🔲 Inpatient Certification: To 2 ER/Outpatient 3 ☐ DOA 28a. Date of Injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 1 Natura 5 ☐ Pending investigation n 24 hours after death.
he Funeral Director: Af pletely filled in by the fu 1 ☐ Yes 2 ☐ No 2 Accident 6 □ Could not be 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide 29a. Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) To the Hosp within 24 hou To the Fune completely fi Medical and manner stated 29b. Signature and title of certifie 10 galenama 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 119 C. North main St

State Registrar

Registrar's Signature

21635

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ 2000 PM Marie Ε. Oyer Decembe Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death Washington County Hospital Hagerstown Washington If Under 1 Year | If Under 24 Hrs. Social Security Number 7. Age (In yrs. last birthday, 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** 1 □ M 2 🗓 F Months Hours Min. 02^{Month, Day, Year} Waynesboro, PA Director 178-16-6416 88 Usual Residence of Decedent 28a-f shov 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Examiner must be notified at Director PA Franklin Waynesboro 1 Yes XX No 10e. Street and Number 10f. Zip Code ö 10g. Citizen of What Country? 23a Funeral 9423 Oyer Dr. 17268 US items death 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 12. Was Decedent Ever in U.S 14. Race - American Indian. Armed Forces?

1 Yes 2 No Black, White, etc. ō Completed by 1 Never Married 2 Married 1 Yes If Yes, Give Maryland 21215-0036 1 ☐ Yes 2X No Specify: white "natural" 3 X Widowed 4 Divorced Year or Dates the Medical Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business Industry (Specify only highest grade completed) permit. Page 1 and 2 should be filed within 72 Department of Health and Mental Hygiene. Important: If item 27 is marked other than 'any injury or other traumatic event, the Me Elementary/Seconday (0-12) College (1-4 or 5+) 12 homemaker own home Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Arthur Miller Beulah Gaugh 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Matthew Oyer .O. Box 527 9423 Oyer Dr. Waynesboro, PA 17268 Baltimore, 20a, Method of Disposition 20c. Location - City or Town, State Waynesboro, PA 20b. Place of Disposition (Name of cemetery, crematory or other place) 1 ☐XBurial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Green Hill Cemetery December 30 2009 Signature of Funeral Service License 22. Name and Address of Facility Grove-Bowersox Funeral Home, Inc 50 S. Broad St. 17268 Waynesboro, Tau 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ disease or condition resulting in death) Medical Examiner Gequentiary list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Due to (or as a consequence of) Cobalt radiation Exami that the death certificate be executed sician and burial-trans that initiated events resulting in death) Last physician Physician/Medical Box 68760 the attending p for use as t IE EEMALE 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy
5 Other (specify) ____ in the past 12 months? Month Pregnant at time of death 4 ☐ Pregnant 9 ☐ Unknown ed by the a 2 🗌 No 9 Unknown P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ been signe should be Records, 1 Yes 2 No 3 Probably 4 Unknown Completed Were autopsy findings available prior to completion of cause of 24a. Was an page 2 s has autopsy perform certificate 1 ☐ Yes 2 ☐ No or Attending Physician: **Division of Vital** 25. Was case referred to medical completed filled in by the funeral director, Be 26. Place of Death (Check only one) examiner?
1 Yes Other: 4 \(\sum \) Nursing Home 5 \(\sum \) Residence 6 \(\sum \) Other (Specify) 2 No ပ္ 1 Inpatient 2 ER/Outpatient 3 DOA this 27. Manner of Death 28b. Time of 28a. Date of injury 28c. Injury at Certificate: 28d. Describe how injury occurred within 24 hours after death.

To the Funeral Director: After (Month, Day, Year) 5 Pending ✓ Natural work' 1 Yes 2 No Investigation 6 Could not be 2 Accident Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide determined Hospital Medical 29a. Certifier 🗹 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated only one) Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certifie 29c. License number 2009

State

Dr Weinberg IIIG Medical

31. Date filed (Month, Day, Year)

DEC 39 2003

32. Aegistrar's Signature

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Registrar

ampis

Hagerstown

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death 1. Decedent's Name (First. Middle, Last) 2. Date of Death Physician/ Month Douglas Robb Paden December 2009 Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Baltimore Towson Gilchrist Hospice If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign Social Security Number 7. Age (In vrs. last birthday) **Funeral** 1 ☐ M 2 ☐ F Days (Month, Day, Yea Hours Min. Country) Dec Ï934 CO Director 312-36-4846 Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10a. State 10b. County Page 1 and 2 should be filed within 72 hours after death with the Maryland ment of Health and Mental Hygiene.
ant: If item 27 is marked other than "natural", or items 23a or 28a-f sho ant: If item 27 is marked other than "natural", or items 23a or 28a-f sho upy or other traumatic event, the Medical Examiner must be notified at "natural", or items 23a or 28a-f sho Director MD Carrol1 Eldersburg 1 Yes 2 No 10f. Zip Code 10e. Street and Number 10g. Citizen of What Country? Funeral 21784 USA 7085 MacBeth Way Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S 14. Race - American Indian TY Yes 2 No 1956-Black, White, etc. Completed by 1 Never Married 2 X Married Baltimore, Maryland 21215-0036 Yes 2 No Specify Specify: white 3 Widowed 4 Divorced 1959 Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) Dept. of Defense physicist Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Georgianna Newcomb ڡ Alfred Robb Paden 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Mrs. Adella M. Paden (spouse) 7085 MacBeth Way, Eldersburg, MD 21784 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition permit. Page 1 a
Department of IImportant: If ite
any injury or ot 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) All County Cremation | 12-18-09 Sykesville, MD 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Haight Funeral Home & Chapel Day Saight Herbert P.O. Box 195 Sykesville, MD 21784 23a. Part 1. Enter the disease, or complications that caused the death. Do-not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final (Rhysician/ Heuroblastoma disease or condition resulting in death) years Medical Due to (or as a consequence of) Examiner Sequentially list conditions if any, leading to immediate cause. Enter Underlying Cause (Disease or linjury Due to (or as a consequence of) attending physician and for use as the burial-transit Hospital or Attending Physician: The law requires that the death certificate be executed that initiated events Due to (or as a consequence of): resulting in death) Last Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy
5 Other (specify) in the past 12 months? Month Day Year Pregnant at time of death 1 Yes 2 D 2 🗌 No n signed by the a ld be detached f 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☑ Unknown been signature 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an this certificate has ral director, page 2 autopsy performed? 1 Yes 2 No 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Be Other: 4 Nursing Home 5 Residence 6 Stother (Specify) Hospital 1 ☐ Yes 2 🛣 No မှ 1 Inpatient 2 ER/Outpatient 3 DOA After thi 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at 28d. Describe how injury occurred Certificate: 1 Natural
2 Accident
3 Suicide
4 Homicide work? 1 ☐ Yes 2 ☐ No 5 Pending To the Hospital or Attendir within 24 hours after death. To the Funeral Director: Af completed filled in by the fu Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation in my arising data that the state of the cause of the Medical 29a, Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check 3 💢 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated only one) 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier ut CRNP R149194 December 17, 2009 NJL

10

State Registrar Marian Grant 31. Date filed (Month, Day, Year)

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

6701 N. Cherks, Towson, MD 21204

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene StateRegistrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Carroll Aldine PRYOR Decem Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Deam Washington Examiner Washington County Hospital Hagerstown 7. Age (In yrs, last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth . Social Security Number 219–14–9095 9. Birthplace (State or Foreign **Funeral** 1 1 M 2 □ F Days Min. Months Hours Nov. 6 I924 85 Maryland Director Usual Residence of Decedent 28a-f shov 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits 72 hours after death with the Maryland Examiner must be notified at Director Maryland Washington Hagerstown 1 ¥ Yes 2 □ No 5 10f. Zip Code 10g. Citizen of What Country? 23a 72 Sunbrook Lane 21742 Funeral U.S.A. items 12. Was Decedent Ever in U.S. Armed Forces?

1 X Yes 2 No 19
If Yes, Give 10 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, þ 1 Never Married 2 Married þ 1945 Maryland 21215-0036 1 ☐ Yes 2 No Specify. white 1947 Specify: "natural" Completed 3 Divorced 4 Divorced Year or Dates the Medical 15. Decedent's Education 16a, Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) permit. Page 1 and 2 should be filed within 72 Department of Health and Mental Hygiene. Important: If item 27 is marked other than ' Elementary/Seconday (0-12) College (1-4 or 5+) traffic Manager furniture Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Robert Redmond Pryor Hazel Susan Lewis 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Patricia A. Pryor - wife 72 Sunbrook Lane, Hagerstown, Maryland 21742 Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Date December 29,2009 ò 1 XBurial 2 Cremation 3 Removal from State Rose Hill Cemetery injury 4 Donation 5 Other (Specify) Hagerstown, Maryland 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Minnich Funeral Home 415 East Wilson Blvd., Hagerstown, Maryland 2174 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Interval Between Immediate Cause (Final Physician/ 501 Medical resulting in death) Due to (or as a consequence of) Examiner Souths Esquentially list conditions, Examine if any, leading to immediate cause. Enter Underlying Cause (Disease or linjury Due to (or as a consequence of) sician and burial-transit that the death certificate be executed that initiated events Due to (or as a consequence of) resulting in death) Last attending physician for use as the buria Physician/Medical Box 68760 IF FEMALE 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ in the past 12 months?

1 Yes 2 No Month Year Pregnant at time of death signed by the a 9 Unknown Unknown P.O. I Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Division of Vital Records, Physician: The law requires 2 No 3 □ Probably 4 □ Unknown cate has been signated by page 2 should by Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed certificate 1 Yes 2 No 25. Was case referred to medical filled in by the funeral director, Be 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 C No မ 1 Inpatient 2 ER/Outpatient 3 DOA 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred Certificate: 1 Natural 5 Pending work? 1 Yes 2 No death. Accident Investigation 24 hours after deat Funeral Director: 3 Suicide 4 Homicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier сотріете within 2 To the I the only one) Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29b. Signature and title of certifie 29c. License number 29d. Date signed (Month, Day, Year) D62588 264, 2009 mpuos

Registrar
DHMH 17 Rev 7/2009

State

05H-LT

egistrar's Signature

251 E. Antietam St.

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

JUDITH MBAOUA

Year)

31. Date filed (Month,

Please Type or Printin Black Indelible 19k8 Fneure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Reg. No. 20 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month Day Year DECEMBER 24, 2009 **Physician** EVELYN THERESA BARNES PROCTOR 5:30 MM /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner CIVISTA LATTI MEDICAL 5. Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year | If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** Year) 1928 1 □ M 2 👿 F Months Days Hours OCTOBER 8. MARYLAND 220-38-2650 Director Usual Residence of Decedent 10a. State 10h County 10c. City. Town or Location 10d. Inside City Limits is marked other than "natural", or items 23a or 28a-f show aumatic event, the Medical Exp. direct must be rediffed at 1 TyYes 2 □ No Director MARYLAND CHARLES WALDORF 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 20602 3605 MOSES WAY, APT, #202 UNITED STATES Funeral 11. Marital Status 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14 Race - American Indian Armed Forces?

1 Yes 2 No
If Yes, Give
Year or Dates: 1 Never Married 2 Married 1 ☐Yes 2 No Specify: Specify: BLACK Baltimore, Maryland 21215-00 3 X Widowed 4 □ Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Flementary/Secondary (0-12) **7TH GRADE** College (1-4or 5+) COOK FOOD SERVICE injury or other traumatic event, 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be 2 should be f and Mental I EDWARD JOHN BARNES HATTIE ELIZABETH SCOTT BARNES 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Pages 1 and 2 Department of Health a Important; If item 27 is CHARLES R. BARNES / SON 935 CLOVIS AVENUE, CAPITOL HEIGHTS, MARYLAND 20743 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 1 Durial 2 □ Cremation 3 □ Removal from State 4 □ Donation 5 □ Other (Specify) ST. PETER'S CEMETERY JAN. 2,2010 WALDORF, MARYLAND 21 Senature of Funeral Service hicensee THORNTON FUNERAL HOME, P.A. 3439 LIVINGSTON ROAD, INDIAN HEAD, MARYLAND 20640 EYDIA C. THORNTON JOHNSON MO0583 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** disease or condition resulting in death) /Medical Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last - Unknown Primary and -trar attending physician a for use as the burial-Box 68760, death certificate be Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 XNo Ye ar Pregnant at time of death 5 ☐ Other (specify) Ö 9 Unknown ۵ Part II. Other significant conditions ontributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Records, þ 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy perform HO POrosis Vital 2**X** No 1 ☐ Yes 2 ☐ No 1 ☐ Yes 25. Was case referred to medical examiner? completely filled in by the funeral director, Be 26. Place of Death (Check only one) Other: 4 \subseteq Nursing Home 5 \subseteq Residence 6 \subseteq Other (Specify) 1 Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA Certification: To oţ 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Division or Attending 1 Natural 5 Pending 1 □Yes 2 □ No 2 Accident investigation 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 ☐ Homicide Hospital 24 hours a 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical 29a. Certifier 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. within 2 29b. Signature and title of cettifie 29c. License number 29d. Date signed (Month, Day, Year) D57708 MS 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)
Abbas Omais, Cenna Medical Center, 7C Post Office Road, Waldorf MD 20602

Registrar
DHMH 17 Rev 1/2001

State

9

31. Date filed (Month, Day, Year) DEC 28 2009

32. Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 2 For State Registrar 42849 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Month Charles R. Parsons Decem<u>be</u>r 2009 Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death Berlin Nursing & Rehabilitation Cente Berlin Worcester 8. Date of Birth 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. Birthplace (State or Foreign Country)
 Maryland Social Security Number **Funeral** 1 **X** M 2 □ F Months Days Hours Min 213-22-8750 709/1928 Director Usual Residence of Decedent 10c. City, Town or Location 10a. State 10b. County Examiner must be notified at 10d. Inside City Limits Director 28a-f 1 Yes 2 X No Maryland Wicomico Willards 5 10e, Street and Number 10f. Zip Code 10g, Citizen of What Country? Funeral 23a 5895 Massey Crossing Rd. 21874 USA Page 1 and 2 should be filed within 72 hours after death 12. Was Decedent Ever in U.S. Armed Forces?

1 ☑ Yes 2 ☐ No If Yes, Give Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. δ 1 Never Married 2 X Married Baltimore, Maryland 21215-0036 1 Yes 2 No Specify: "natural", 3 Divorced 4 Divorced Completed Year or Dates. Army White Department of Health and Mental Hygiene.
Importants If item 27 is marked other than "natur any injury or other traumatic event, the Medical once. 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) Carpenter Carpentry Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ္ Jacob Parsons Ida Parsons 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Bertha Parsons/wife 5895 Massey Crossing Rd., Willards, MD 21874 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State 1 🖾 Burial 2 🗆 Cremation 3 🗆 Removal from State Springhill Memory 4 ☐ Donation 5 ☐ Other (Specify) 12/21/2009 Hebron, Maryland ardens 21. Signature of Funeral Service Licens HOIIOWAY Funeral Home P.A. 501 Snow Hill Rd., Salisbury, Maryland 21804 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between shock, or heart failure. List only one cause on each line Immediate Cause (Final Onset and Death Physician/ Vneumonia disease or condition resulting in death) Medical Due to (or as a consequence of): Examiner Mouselly Securitally for conditions if any, leading to immediate cause. Enter Underlying tustati Curco 1 Hospital or Attending Physician: The law requires that the death certificate be executed Cause (Disease or linjury ng physician and as the burial-tran that initiated events resulting in death) Last Be Completed by Physician/Medical IF FEMALE: use 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy 5 Other (specify) ____ in the past 12 months?
1 Yes 2 No ō Month Day Year been signed by the should be detached 9 Unknown Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an page 2 autopsy performed? Yes 2 X No 1 🗌 Yes 25. Was case referred to medical 26. Place of Death (Check only one) 1 Tyes 2 No Other: မ 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) To the Hospital or Autenance within 24 hours after death.

To the Funeral Director: After this many and filled in by the funeral 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred 1 Natural
2 Accident
3 Suicide
4 Homicide 5 Pending 1 Yes 2 No Investigation 6 Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) determined Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated only one) 29b. Signature and title of certifier 16/2009 Medical 0069257 DITECTOY

Registrar DHMH 17 Rev 7/2009

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Box 68760

Records, P.O.

Division of Vital

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30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

32. Registrar's Signatur

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1audia 31. Date filed (Month.

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar AMEND#19aperFH, 12/23/09, BMW, McCo Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Day Month Year **Physician** 2018 M December 20, 2009 RAMESH /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner PRINCE GEORGES NEW CARROLLTON 7305 SARA ST. If Under 1 Year | If Under 24 Hrs.

Months Days Hours Min. 6. Sex Birthplace (State or Foreign Country) 5. Social Security Number 7. Age (In vrs. last birthday) **Funeral** 1**X** M 2 □ F Months 23, 1958 Director 51 INDIA 578-86-7650 Usual Residence of Decedent 10d. Inside City Limits 10b. County 10c. City, Town or Location 28a-f show Examiner must be notified at 1 TYes 2 □ No Directo PRINCE GEORGES NEW CARROLLTON MD. 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 23a or filed within 72 hours after death with 7305 SARA ST. 20784 U.S.A. Funeral 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 Yes 2 No If Yes, Give Year or Dates: 1 ☐ Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 ō 1 ☐ Yes 2 ☐XNo Specify: þ 3 ☐ Widowed 4 ☐ Divorced ÁSIAN INDIAN Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) PRINTER PRINTING 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Pages 1 and 2 should be and Mental RAMCHANDRA **PAWAR** LEELA DESHMUKH 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 27 Is r of Health JYOTSNA PAWA/wife 7305 SARA ST., NEW CARROLLTON, MD. 20784 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 □ Donation 5 □ Other (Specify) CHAMBERS CREMATORY 12-24-2009 RIVERDALE, MD. 22. Name and Address of Facility CHAMBERS FUNERAL HOME & CREMATORIUM, P.A. MOO091 5801 CLEVELAND AVE., RIVERDALE, MD. 20737 Signature of Funeral Service Licensee 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** Asphy x 1al /Medical Due to (or as a consequence of): **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examine ysician and e burial-trans Due to (or as a consequence of): Box 68760, Physician/Medical 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant in the past 12 months?
1 □ Yes 2 □ No 23d. Date of delivery 3 Ectopic pregnancy Month Day Year Pregnant at time of death 5 Other (specify) P.0. 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Division of Vital Records, þ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed 1 □Yes 2 ☑No 1 ☐Yes 2 ☐ No Hospital or Attending Physician; Be 25. Was case referred to medical 26. Place of Death (Check only one) examiner2 Other: 4 Nursing Home 5 Aesidence 6 Other (Specify) ဥ 1 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of Injury (Month, Day, Year) 28d. Describe how injury occurred / 27. Manner of Death 28b. Time of Certification: 5 Pending investigation 1 Natural with a cord December 20204 945 M 1 ☐ Yes 2 ☐ No To the Hospital or Attendi within 24 hours after death. To the Funeral Director: A completely filled in by the ft 2 Accident 28e. Place of Injury At home, farm, street, factory, office building, etc. (Specify) 6 Could not be determined 3 ☐ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide New Capaciton Sara horne 29a. Certifier 1 🗆 CertifyIng Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical (Check only 22 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 300/ 14-25 3. Registrar's Signature 31. Date filed (Month, Day, Year) State Registrar

DHMH 17 Rev 1/2001

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			1. Decedent's Name (First, Middle, Last)									2. Date of Death Month Day Year 3. Time of			
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	Funeral		5. Social Security Number 6. S	Sex 7. Ag	ge (In yrs. la		If Under Months	1 Year Days	If Under Hours	Min.	8. Date of Birt (Month, Da	h y, Ye <i>ar)</i>		place (State or Foreig intry)	ΉΠ
	Director		215-20-9234 Usual Residence of Decedent		83	2 113.				[A	pril 6	,1927	Mar	yland	
	and		10a. State 10b. County		10c. City,	Town or Lo	ocation							10d. Inside City Limits	s
	f she	ō	Maryland Washing	ton	[[a] ÷]]	.iamsp	ort							1 □Yes 2 🕱 No	0
	the 28a	Director	Maryland Washing	COH	AATTT	Janusp	10f. Zip	Code				10g. Citizer	n of What Cou	intry?	_
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	ns 2;	Funeral	11. Marital Status	12. Was Decedent	Ever in U.S	. 13.				gin? (Spec	cify Yes or No-				
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Maryland	2 sh h and rism raum		19a. Informant's Name/Relationship (Dana L. Sheffler	• •	ahter						Route Numbers				
	s 1 and 2 should be filed within 7 of Health and Mental Hygiene. item 27 is marked other than "r other traumatic event, the "Med			(preb pad		ace of Dispo					ate		tion - City or T		_
jor	ges if ite		20a. Method of Disposition 1 ABurial 2 ☐ Cremation 3 ☐		ce	metery, cre	matory or o	ther place	· .						
Baltimore,	rtmer rtant:		4 Donation 5 Other (Specify) Mt. View Cemetery Dec. 29, 2009 Sharpsbu									sburg,	Maryland	_	
Bal	permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at ance.		21 Organiture of John and Address of Facility Osborne Funeral Home P.A. 425 South Conocoche St. Williamsport, Maryland 21795										onococheag	gι	
			23a Part T. Enter the disease, or com	unlications that saying	d the death								75	Approximate	-
			shock, or heart failure. List only	one cause on each l	line.	4								Approximate Interval Between Onset and Death	
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68760,	aath certificate be executed attending physician and for use as the burial-transit	an/Medical													_
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	ital or ral property affine af	S													
	To the Hospital or Attanding Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit	Medical	(Check only 2 Medical Example 12	hysician: To the bes miner: On the basis	of examinat										
	the I	Med	one)	and manner s			20	c. License	numbar			20d Date	signed (Monti	n Day Year)	_
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15	H5+1		30. Name and address of person who	completed cause of	death (Item	23a) (Type	, Print)	ans	Rd	Boo.	nshon	N G	10.21	28, 2009	
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. death	r item iner m		11. Marital Status	ied 2 Married	12. Was Decedent E Armed Forces?		13. V	/as Deced Yes, spec	ent of His fy Cubar	spanic Ori	gin? (Spec n, Puerto F	cify Yes or No Rican, etc.)		14. Race - Am Black, Whi	
Karols 21215-0036 within 72 hours after death with the Maryland	ital Hygiene. ed other than "natural", or items 23a or 28a-f show event, the Medical Examiner must be notified at	ed by	3 ☐ W idowed		1 ☐ Yes 2 🔀 If Yes, Give Year or Dates.	No	1	☐ Yes 2	∏ No	Specify:				specify ite	2
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M CAROL RIC Baltimore, Maryland	Department of Health and Mental Important: If item 27 is marked any injury or other traumatic ev once.		19a. Informant's Na David R											or Town, State, Z	· · · · · ·
ARC ore,	of Hez fitem rothe		20a. Method of Disp	osition	Removal from State	20b. Pla	ce of Dispos netery, crem	sition (Nam	e of			ate		LCESS A Location - City o	
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	ysician/		Immediate Cause (disease or condition resulting in death)	Final	a. CHRONIC		STRI	CTI	UR	Pu	LMOR	ARY	Dis	RASR	Onset and Death
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Division of Vital Records, P.O. Box 68760 and or Attending Physician: The law requires that the death certificate b	ing ph	Physician/Medical	IF FEMALE:		00.16	,				_	-				
ox 6	attend for us	cian,	23b. Was decedent in the past 12 r	nonths?	23c. If yes, outcome of Live Birth	2 Fetal of	death 3	Ectopic p		у			l	23d. Date of de Month	elivery Day Year
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ViSi	ifter de Sirecto in by th	Certificate:	3 ☐ Suicide 4 ☐ Homicide	6 ☐ Could not be determined	28e. Place of Inju building, etc		e, farm, stre	et, factory,	office		2	8f. Location (ural Route Number,
Division of Vital Records, P.O. Box 68760 the Hospital or Attending Physician: The law requires that the death certificate be			29a. Certifier	Certifying Phy	sician: To the best of	my knowled	lge, death o	ccured at t	he time,	date and p	place, and	due to the ca	ause(s) a	ınd manner as st	ated.
the Ho	nin 24 l	Medical		☐ Medical Exam ☐ Certifying Nur	iner: On the basis of ex se Practioner: To the t	kamination a best of mv k	nd/or investi nowledge, d	gation, in n	y opinion ed at the	n, death oc	curred at t	he time, date	and place	e, and due to the	cause(s) and manner stated.
و . ا	10 00		29b. Signature and	file of certifier				29c.	License	number	illa			ate signed (Moni	
	5.1		30. Name and addre	ess of person who	completed cause of de	eath (Item 2)	3a) (Type. P	int)	Do	U > E	110		- 1	2/17/0	/
	80		Coffeigi	u WA	ms P.	O BO	¥ 17	33	SA	Cin B	ney	и	9	2/80	2
	State Registra	e	31. Date filed (Month	n, Day, Year) NEC 18 2	completed cause of de	r's Signatur	1. de	ake)			/				

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** Dolores R. Year Rayne 502 M 2009 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner eninsula Regional Medical Center Salisburi Wicinico If Under 1 Year | If Under 24 Hrs. Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) 05/25/1930 6. Sex **Funeral** 1 □ M 2 🕱 F Months Days Min 79 **Director** Delaware Usual Residence of Decedent permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, Ite MA-Acal Eventment by mother traumatic event, Ite MA-Acal Eventment by mother traumatic avent, 10a, State 10c. City, Town or Location 10b. County 10d. Inside City Limits 27 is marked other than "natural", or items 23a or 28a-f shov traumatic event, it a Martical Evantizat nust be notified at Director 1 ☐Yes 2 No Maryland Wicomico Salisbury 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 209 Sandy Bottom Court 21804 USA Funeral Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 Never Married 2 Married Baltimore, Maryland 21215-0036 þ 1 ☐Yes 2 📉 No Specify: Specify: 3 X Widowed 4 ☐ Divorced white Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) banking manager 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be James L. Purcell Betty Nelson ၉ 19a. Informant's Name/Relationship (Type. Print)
Christine Justice/daughter 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 8635 Steeple Chase Drive, Roswell, GA 30076 20b. Place of Disposition (Name of cemetery, crematory or other place WICOMICO MEMORIAL 20a. Method of Disposition Date 20c. Location - City or Town, State 1X Burial 2 ☐ Cremation 3 ☐ Removal from State 12/23/09 4 □ Donation 5 □ Other (Specify) Salisbury, MD Park 21. Signature of Funeral Service Lice 22. Name and Address of Facility
Holloway Funeral Home Professional Association 501 Snow Hill Rd., Salisbury, MD 21804 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** Metastatic Ovarian canan /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to (or as a consequence of): or Attending Physician: The law requires that the death certificate be executed and burial-tran Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, attending physician Physician/Medical as IF FEMALE: 23c. If yes, outcome of pregnancy 23b. Was decedent pregnant 23d. Date of delivery 1 ☐ Live birth 2 ☐ Fetal death 4 ☐ Pregnant at time of death 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 No Month Day Year 5 ☐ Other (specify) the 9 Unknown cate has been signed by page 2 should be detach Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ģ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a, Was an certificate has autopsy 1 □ Yes 2 🗀 No 1 ☐ Yes Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1∐Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA After this Certification: To 28a. Date of Injury (Month, Day, Year) 27. Manner of Death 28b. Time of Injury 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural 2 Accident 5 ☐ Pending investigation ours after death.

neral Director; A
filled in by the fu 1 ☐ Yes 2 ☐ No 6 □ Could not be 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 ☐ Homicide within 24 hours a 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical and manner stated. 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month. Day. Year)

8

Su

State Registrar Nah

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

NAMESAN

whe

DR. USHA

31. Date filed (Month Day)

1415. S. DIVISION

Registrar's Signature

2051350

ST SALISBURY

12/19/2009

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 42854 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Month 3,20 PM Medical 4a. Facility Name (if not institution, give street and number Examiner 4b. City, Town, or Location of Death unty of Death 10 Sex Age (In yrs. last birthday) If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** (Month, Day, 1 □ M 2 🔀 F Months Days Hours Min. Director Yrs Usual Residence of Decedent permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at 10a. State 10b. County 10d. Inside City Limits Director 1 Yes 2 No 10e. Street and Numbe 10f. Zip Code 10g. Citizen of What Country? Funeral Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 11. Marital Status 14. Race - American Indian Armed Forces Black, White, etc. Completed by 1 Never Married 2 Married 2 No Yes Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify. If Yes, Give 3
Widowed 4 Divorced Year or Dates Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT_puse retired) 15. Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) Be 18. Mother's Name (First, Middle, Maiden Surnar 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street State, Zip Code) 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date 1 Burial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify) cemetery, crematory or other place) 21. Signature of Funeral Service Licensee ons 2593 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Immediate Cause (Final Onset and Death Physician/ disease or condition resulting in death) Medical Due to (or as a consequence of): **Examiner** Sequentially list conditions, if any, feading to immediate cause. Enter Underlying Cause (Disease or linjury Examine Due to (or as a consequence of, for use as the burial-transit Hospital or Attending Physician: The law requires that the death certificate be executed and that initiated events resulting in death) Last Due to (or as a consequence of) To the Hospital or Attending Physician: The law requires that the vegan continuous as within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician completed filled in by the funeral director, page 2 should be detached for use as the burial Physician/Medical Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?

1 Yes 2 No Month Pregnant at time of death 5 Other (specify) Day Year 4 ☐ Pregnam : 9 ☐ Unknown Unknown Division of Vital Records, P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 2 No 3 Probably 4 Unknown 1 Yes 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed Yes 2 No 1 Yes 2 No 25. Was case referred to medical examiner?

1 Yes 2 No Be 26. Place of Death (Check only one) Hospital: Other: မ 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28c. Injury at work? 1 ☐ Yes 28b. Time of Certificate: 28d. Describe how injury occurred 1 Natural 5 Pending 2 Accident
3 Suicide 2 No Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, Homicide determined City or Town, State) Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check only one) 29b. Signature and title of ertifier 29d. Date signed (Month. Day, Year) + (06066) who completed cause of death (Item 23a) (Type, Print)

Registrar

State

31. Date filed (Month, Day, Year)

DEC 29

5

Registrar's Signature

		•	For State Registrar	State of Mai	ryiana /		tment of F ficate of L		and iviental H	/gier Reg. l		0 10055
	Physicia		1. Decedent's Name (First, Middle, La Marsha Gayl	,					2. Date of D Month DECEN		Day 7 Ye	3. Mms of Death of ar 5/6 PM
	Medic Examin		4a. Facility Name (if not institution, give	0 0	Hmor		b. City, Town, o	r Location o	f Death		4c. County of [
	Funeral Director		5. Social Security Number 6. S		In yrs. last bin	thday)	If Under 1 Year Months Days	If Under 2 Hours		irth lay, Year	9. 144 We	Birthplace (State or Foreign Country)
pue	show d at	o	Usual Residence of Decedent 10a. State 10b. County	1	I0c. City, Tow	n or Locat	tion					10d. Inside City Limits
e Maryla	. 28a-f	Director	Maryland Prince	Georges				Greenk	ælt			1 ☐ Yes 2 🗖 No
h with the	ns 23a or nust be r	Funeral D	10e. Street and Number 57-B Ridge Road				10f. Zip Code	20770			Citizen of Wha	t Country?
21215-0036 within 72 hours after death with the Maryland	ital Hygiene. ed other than "natural", or items 23a or 28a-f sho event, the Medical Examiner must be notified at	þ	11. Marital Status 1 ☐ Never Married 2 ☐ Married 3 🌠 Widowed 4 ☐ Divorced	12. Was Decedent Eve Armed Forces? 1 Yes 2 No If Yes, Give Year or Dates.	0	1 []Yes 2. ★ No	Specify:	in? (Specify Yes or No , Puerto Rican, etc.)	-	Black, V	American Indian, Vhite, etc. White
215-	e. Ian "na Medic	Completed	15. Decedent's E (Specify only highest gr Elementary/Seconday (0-12)	ducation ade completed) College (1-4 or 5+)		(Give kin	nt's Usual Occup d of work done o NOT use retired)	during most	of working	16b.	Kind of Busine	ess Industry
nd 21,	Hygiene other th	a l	17. Father's Name (First, Middle, Last)	4		Vice	Preside		r's Name (First, Middle		Dental	Corp
ylanod be file	Mental arked c atic eve	욘	Herbert H. Bus	sard					nestine Sco		n Surname)	
, Maryland nd 2 should be filed	ealth and m 27 is m		19a. Informant's Name/Relationship (7 Cynthia L. Kasza,						r or Rural Route Numb e, Westmin			
Baltimore,	Department of Health and Mental Hygiene, Important: If iten 27 is marked other tha any injury or other traumatic event, the I once.		20a. Method of Disposition 1 ☐ Burial 2 🔀 Cremation 3 ☐ 4 ☐ Donation 5 ☐ Other (Speci	Removal from State	SOUT	h ^{cremat}	ion (Name of tory or other place Cremate	ory	Date 12/18/2009	1	Location - City	y or Town, State
Balti permit.	Depar Impor any in		21. Signature of Funeral Service Licens	see Sun Area			lame and Addres		Myers-Dur St, Taney	cbor ztow	aw Fundan, MD	eral Home 21787
			23a. Parl 1. Enter the disease, or com	plications that caused the cause on each line.	ne death. Do r							Approximate Interval Between
	/sician/ Medical		Immediate Cause (Final disease or condition resulting in death)	a. SCPSI Due to (or as a c	Sonsequence	of).						Onset and Death
Ex	aminer	_	Sequentially list conditions,	b. bacte	eren	119						Iday
nted	nd ransit	amine	if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury that initiated events	Due to (or as a c	consequence	of):)
760 ficate be executed	physician and the burial-transit	ical Ex	resulting in death) Last	Due to (or as a c	onsequence	of):						
68760 certificate b	ding ph	/Med	IF FEMALE:	23c. If yes, outcome of	pregnancy							
Box death o	been signed by the attending should be detached for use as	Completed by Physician/Medical Examiner	23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown	1 Live Birth 2 A Pregnant at ti	Fetal deatl		ctopic pregnand other (specify)	у			23d. Date of Month	delivery Day Year
cords, P.O. aw requires that the	signed by	l by PI	Part II. Other significant conditions of Stanffican Fa		not resulting i	in the und	erlying cause giv	ven in Part i.				e to the cause of death?
ords w requir	s been s	pletec	J	rtenjoli.	seas	So			24a. Was	an	24b. Were	autopsy findings available
Rec	cate ha		J			_			peri 1 \(\sum \) Yes	opsy ormed? 2 😿	deat	to completion of cause of h? Yes 2 No
Vital ysician	is certifi director	To Be	25. Was case referred to medical examiner? 1 Yes 2 No	Hospital:	1 2 □ ER/Ou	utpatient	Oth	ar-	n (Check only one)	idence	6 ☐ Other (S	necify)
n of	After thi funeral		27. Manner of Death 1 ☑ Natural 5 ☐ Pending	28a. Date of injury (Month, Day, Y	28b.	Time of injury	28c. Injury work	y at	28d. Describe			
Division of Vital Records, lat or Attending Physician: The law requires or After death	winn 24 mous aren beau. To the Funeral Director. After this certificate has completed filled in by the funeral director, page 2.	Certificate:	2 ☐ Accident Investigation 3 ☐ Suicide 6 ☐ Could not be 4 ☐ Homicide determined			ırm, street		Yes 2 ∐ I	1			Rural Route Number,
he Hospita	he Funeral	Medical	(Check 2 ☐ Medical Exam	sician: To the best of my iner: On the basis of exar se Practioner: To the be	mination and/c	or investiga	ition, in my opinic	on, death occ	curred at the time, date	and plac	ce, and due to t	the cause(s) and manner stated.
	. 11		29b. Signature and title of certifier	110	1. ()		29c. License	number		29d. C	Date signed (Me	onth, Day, Year)
	15		30. Name and address of person who	completed cause of deat	th (Item 23a) (Type, Prin	1) 2401	> -U W. Bell	Lyedere Av	 }	Baltim	ore, MD 21215
	Stat	e	31. Date filed (Month, Day, Year)	32. Registrar's	Signature		m110	DITA	11/1/1	11/	rrure	
	Registra 7 Rev 7/20		DEC 21 2	UUJI Seneu	v B.	4	ares .					

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Day **Physician** Gladys C. Shires December 27. 2009 /Medical 4a. Facility Name (If not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death 70 Patterson Avenue Perryville Cecil Birthplace (State or Foreign Country) 5. Social Security Number 7. Age (In vrs. last birthday) Date of Birth (Month, Day, Year) **Funeral** Hours Days 1 ☐ M 2 ☐ F Months Director 91 12/27/1918 Manufand <u> 212-50-7326</u> Usual Residence of Decedent Maryland 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits 28a-f show or than "natural", or items 23a or 28a-f show the Medical Examinating the southed at Director 1 ☐ Yes 2 XNo MD Cecis Perruville the 10e. Street and Number 10g. Citizen of What Country? 10f Zip Code with 1 by Funeral 70 Patterson Avenue U.S.A. death 12. Was Decedent Ever in U.S. Armed Forces? 1 Tyes 2 No 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14 Bace - American Indian permit. Pages 1 and 2 should be filed within 72 hours after to Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or iter any injury or other traumatic event, the Modical Examinations. Black, White, etc. 1 Yes 2 If Yes, Give Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☑ No Specify Specify: White 3 Nidowed 4 Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Homemaker Home. 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be ဂ Warner Black Taulor Mabel Aiken 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Gloria Holcomb (Daughter) 339 Quaker Bottom Road, Havre de Grace. MD £1078 20a. Method of Disposition
11 Burial 2 □ Cremation 3 □ Removal from State 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 4 ☐ Donation 5 ☐ Other (Specify) Harford Mem. Gardens 12/30/2009 Aberdeen, Maryland 22. Name and Address of Facility Zellman Functal Home, P.A. of Funeral Service Licensee 123 S. Washington Street, Havre de Grace, MD 21078 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** /Medical Due to (or as a consequence of) Examiner Sequentially list conditions Examiner Due to (or as a consequence of) and the state of t law requires that the death certificate be executed and burial-tran Due to (or as a consequence of): P.O. Box 68760. the attending physician Physician/Medical the as IF FEMALE nse If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy ō in the past 12 months? 1 ☐ Yes 2 No Month Day 5 ☐ Other (specify) signed by the a d be detached for 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, þ 1 ☐ Yes 2 No 3 ☐ Probably 4 ☐ Unknown page 2 should Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has autopsy performed? Yes 2200 certificate 1 □Yes 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) 1 ☐ Yes 2 No Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To After this funeral c 28a. Date of Injury (Month, Day, Year) 27. Manner of Death To the Hospital or Attending Pl within 24 hours after death. To the Funeral Director: After the completely filled in by the funeral 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural 5 ☐ Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 ☐ Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Ledical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical (Check only one) 29b. Signature and title of certifie 29c. License number 29d. Date signed (Month, Day, Year)

State

DHMH 17 Rev 1/2001

Registrar

31. Date filed (Month, Day, Year)

30-Narthe and address of person who completed cause of death (Item 23a) (Type, Print) 150n

MO

32. Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month Day **Physician** Mohan 1al Sahu 2202 December 14, 2009 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Suburban Hospital Bethesda Montgomery | If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth (Month, Day, Year) | February 10, 1950 5. Social Security Number 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign Funeral Months 1 M 2 □ F None 59 India Director Usual Residence of Decedent with the Maryland 10a. State 10c. City, Town or Location 28a-f show 10d. Inside City Limits ral", or items 23a or 28a-f s Examiner must be notified Director Maryland Montgomery Germantown 1 ☐ Yes 2 ▼ No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 20874 19631 Crystal Rock Drive, Apartment #11 India permit. Pages 1 and 2 should be filed within 72 hours after death a Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23 any Injury or other traumatic event, If a Medical Examination and Injury or other traumatic event, If a Medical Examination and Injury or other traumatic event, If a Medical Examination and Injury or other traumatic event, If a Medical Examination and Injury or other traumatic event, If a Medical Examination and Injury or other traumatic event. by Funeral 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian. 11. Marital Status 1 ∐Yes 2 X No If Yes, Give Year or Dates: 1 ☐ Never Married 2 X Married altimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify. Specify: Asian Indian 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Politician Social Work 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Arjun 1ol Sahu Bhagwantin Sahu ဥ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Mathura Bai Sahu / Wife 19631 Crystal Rock Drive, Apartment #11, Germantown, MD 20874 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State December 19, 1 ☐ Burial 2 ☑ Cremation 3 ☐ Removal from State Smithsburg, Maryland 4 ☐ Donation 5 ☐ Other (Specify) Smithsburg Crematory 2009 21. Signature of Funeral Service Lie 22. Name and Address of Facility Keeney & Basford P.A. Funeral Home M M01473 106 East Church Street, Frederick, Maryland 21701 Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such es cardiac or respiratory arrest, shock, or heart failure. Itst only one cause on each line. 23a. Pan 1. Enter the disease Immediate Cause (Final disease or condition resulting in death) **Physician** Multiple Trauma /Medical Due to (or as a consequence of): Examiner Being Struck By Vehicle Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to (or as a consequence of) sate has been signed by the attending physician and page 2 should be detached for use as the burial-trar Due to (or as a consequence of) P.O. Box 68760, Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant in the past 12 months? 23d. Date of delivery 3 🗆 Ectopic pregnancy Month Dav Year 4 Pregnant at time of death 5 ☐ Other (specify) I∐Yes 2∐No 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, δ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 🖾 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an autopsy performed? 1 ⊠Yes 2 □ No certificate Physiclan: 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 \(\text{Nursing Home} \) 5 \(\text{Residence} \) 6 \(\text{Other} \(\text{Specify} \) Hospital: 11 Yes 2 □ No 2 1 ☐ Inpatient 2 X ER/Outpatient 3 ☐ DOA After this funeral 28a. Date of Injury (Month, Day, Year) Dec. 14, 2009 al or Attending P s after death. Certification: 27. Manner of Death 28b. Time of Injury 28c. Injury at Work? 28d. Describe how injury occurred To the Hosp...
within 24 hours after dean..
To the Funeral Director: After 1 Natural 5 Pending investigetion 1759 1 □Yes 2 Tx No As Pedestrian Stepped Into Road 2 X Accident 6 ☐ Could not be 3 ☐ Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide On Street Germantown Road, Germantown 1 X Certifying Physicien: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical (Check only one) and manner stated. 29b. Signature and title of Date signed (Month, Day, Year)

Registrar

State

30. Name and address of person who comp

31. Date filed (Month, Day, Year) DEC 18 200

Willie C. Blair, M.D.

hus Mohan

Darks

7525 Greenway Center Drive, Suite 211, Greenbelt, Maryland 20770

ted cause of death (Item 23a) (Type, Print)

32. Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

			State of Maryland / Department of Health and Mental Hygie 1- State of Maryland / Department of Health and Mental Hygie Certificate of Death Reg.	2003 42030
			Decedent's Name (First, Middle, Last) 2. Date of Death	3. Time of Death
	Physici			Day 2009 4:45PM
	/Medic Examir		di Control di Control	4c. County of Death
			SPA CREEK CENTER Annapolis	Anne Arundel
	Funeral		5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth	9. Birthplace (State or Foreign
	Director		217162646 10 85 Yrs. 1-21-	24 Maryland
	pu k		Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location	10d. Inside City Limits
	eho eho	7		1 √2 Yes 2 □ No
	8a-1	Director	mD Calvert CHESAPEAKE BEACH	
	with t	ä	10e. Street and Number 10f. Zip Code 10g.	. Citizen of What Country?
	s 23	erai	77/0 OLD JAYSIDE KD JO73J 11 Marital Status 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-	USA 14. Race - American Indian,
	lter d	Funerai	11. Marital Status 12. Was Decedent Ever in U.S. Amed Forces? 1 Never Married	Black, White, etc.
336	urs af	by F	If Yes, Give 1 Yes 2 No Specify:	Specify: White
21215-0036	be filed within 72 hours after death with the Maryland stal Hygliene. do other then "neturel", or flems 23a or 28a-1 ehow event, the Medical Evant arminative notified at	ted	15. Decedent's Education 16a. Decedent's Usual Occupation 16	b. Kind of Business/Industry
215	nin 7.	pje	(Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+)	
21	d withi	Completed	Nursing Assistant	Hospital
	be filed tal Hygird of other	Be C	17. Father's Name (First, Middle, Last)	iden Sumame)
/la	should be filed withli and Mental Hygiene. is marked other then aumatic event, Ira M	2		
Maryland	S 8 8		19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, C	ity or Town, State, Zip Code)
	1 and 2 Health tem 27		Richard Finfrock - Grandson 7710 Old Bayside Road, Chesapea	
Baltimore,	0 0		20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) □ XBurial 2 □ Cremation 3 □ Removal from State	c. Location - City or Town, State
Ĕ	Pannen int:		'4 □Donation 5 □Other (Specify) Cedar Lawn Cemetery 12/23/09 Ha	gerstown, Maryland
alt	permit. Departn importe any inju		21. Signature of Funeral Service Licensee 22. Name and Address of Facility Minnich Fun	eral Home
_	89 = 29		Fred L. Westal 415 E. Wilson Blvd. Hagerst	
п			23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line.	Interval Between
	Pnysician		Immediate Cause (Final disease or condition	Onset and Death
	/Medical Examiner		resulting in death) Due to (or as ** onsequence of ;	
	Examiner		Sequentially list conditions. b. Yew Market Value Valu	
-	p #	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	
	and trans	cam	that initiated events c. resulting in death) Last Due to (or as a consequence of):	
8760,	cian cian buria	ai E	Due to (of as a consequence of).	
87	The law requires that the death certificate be executed the has been signed by the attending physician and bage 2 should be detached for use as the burial-transit	dicai	d	
9 x	eath certific attending p			22d Date of delivery
Вох	atten atten for us	Physician/Me	23b. Was decedent pregnant in the past 12 months? 4 Pregnant at time of death 5 Other (specify)	23d. Date of delivery Month Day Year
o.	at the de by the tached	ysic	1 Yes 2 Wo 9 Unknown 9 Unknown	
Δ.	that the ed by detact	Ph	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobac	cco use contribute to the cause of death?
ds,	sign d be	d by	6	2 No 3 Probably 4 Unknown
Ö	w require been si should I	ete	24a. Was an	24b. Were autopsy findings available
že	has has	Completed	E 24d. Wrds Autopsy performs	prior to completion of cause of
Vital Records,				No 1 ☐ Yes 2 ☐ No
V.	rec rec	Be	examiner?	
ō	Phys	5 T	1 Inpatient 2 EH/Outpatient 3 DOA 4 Envirsing Home 5 Hesidence	
no	ding I h. After funer	tion	27. Manner of Death 28a. Date of Injury 28b. Time of Injury 28c. Injury at 28d. Describe how Work? 28d. Describe how Work? 1 Accident investigation	,,
S	Attendi death. ctor: A y the fu	fica	2 Accident investigation 2 Accident 2 Accide	et and Number or Rural Route Number,
Division	if or Attend efter death Director:	Certification;	4 Homicide determined building, etc. (Specify)	
	To the Hospital or Attending within 24 hours efter death. To the Funerel Director; Afte completely filled in by the fune			se(s) and manner as stated.
	the Ho Jin 24 P the Fu	Medical	(Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and manner stated.	and place, and due to the cause(s)
	To the within ? To the comple	Me	29b. Signature and title of certifier 29c. License number 29d	I. Date signed (Month, Day, Year)
	25		Martin humas NAC. RISIR71	12/22/09
0	P		30. Name and address of person who completed cause of death (Item 23a) (Type, Print)	- 1
			35 milestale lane annapolis, mo 2140	*
	Sta	te		
	Registr	ar	DFC 2 2 2009	

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death **Physician** December 2009 7:42 A Betty Swain Jane /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Ravenwood Lutheran Village Washington Hagerstown 8. Date of Birth (Month, Day, Sept 21 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) If Under 1 Year | If Under 24 Hrs. 9. Birthplace (State or Foreign **Funeral** Months Days Hours Min. 1 M 2 X F Maryl and 83 Sept 1926 219-20-2109 Director Usual Residence of Decedent the Maryland 10d. Inside City Limits 10b. County 10c. City, Town or Location 28a-f show ral", or items 23a or 28a-f shov Examirer must be rotified at 1 ☐ Wes 2 ☐ No Directo Maryland Washington Hagerstown 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? U.S.A. 21740 "natural", or items 23a 1183 Luther Drive #504 Completed by Funeral Pages 1 and 2 should be filed within 72 hours after death 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ▼ No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 11. Marital Status 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 □ Yes 2 □ XNo Specify. 3 X Widowed 4 □ Divorced White 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) County Schools Driver 7 is marked other traumatic event, I 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) ant of Health and Mental H
t: If item 27 is marked oth
y or other traumatic even Be Arthur Martin Smith Ruth Elizabeth Harbaugh ္ရ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) E. Ann Moore / Daughter 67 Watkins Ferry Way Martinsburg, WV 25404 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Department of important: If any injury or once. Boonsboro Cemetery 12/30/2009 | Boonsboro, Maryland 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Bast-Stauffer Funeral Home, PA 7606 Old National Pike Boonsboro, MD 21713 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause a each line. Immediate Cause (Final **Physician** Cerebrovascular accider disease or condition resulting in death) /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying that initiated events resulting in death) Last Examiner Due to (or as a consequence of) or Attending Physician: The law requires that the death certificate be executed ate has been signed by the attending physician and page 2 should be detached for use as the burial-transi Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760 Physician/Medical IF FEMALE 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 Tectopic pregnancy in the past 12 months? 1 ☐ Yes 2 No Month Day Year 5 ☐ Other (specify) 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? à 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? 1 Yes 2 240 2 No 1 ☐ Yes 25. Was case referred to medical examiner? funeral director, Be 26. Place of Death (Check only one) Other: ANursing Home 5 Residence 6 Other (Specify) Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 1 Yes 2 ₩0 Certification: To After this 28a. Date of Injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural 5 Pending after death.

I Director: A 1 ☐ Yes 2 ☐ No 2 Accident investigation 6 Could not be 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) Location (Street and Number or Rural Route Number, City or Town, State) filled in by determined 4 Homicide within 24 hours a Hospital 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Medical (Check only

3H-6

State Registrar

29b. Signature and title of certifier

HAR

(

ORIGINAL

23a) (Type, Print)

29c. License number

29d. Date signed (Month, Day, Year)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Month Year Charlotte Marie Smith 2009 Medical 4a. Facility Name (if not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death **Examiner** Washington Washington County Hospital Hagerstown Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year I If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** 1 □ M 2 🏝 F 230-24-0663 83 Months Days Hours 0871671926 Director Usual Residence of Decedent or 28a-f show s notified at 10b. County 10c. City, Town or Location 10d. Inside City Limits 72 hours after death with the Maryland Director MD Washington Boonsboro 1 🛚 Yes 2 🗆 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 5 "natural", or items 23a o 21713 Funeral US 141 S. Main Street Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 11. Marital Status 14. Race - American Indian. Armed Forces?
1 ☐ Yes 2★ No Black, White, etc. þ 1 Never Married 2 Married Yes Baltimore, Maryland 21215-0036 Specify: White 1 Yes 2 X No Specify: If Yes, Give 3 Widowed 4 Divorced Completed Year or Dates Medical 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) marked other than matic event, the Me Elementary/Seconday (0-12) Page 1 and 2 should be filed within ment of Health and Mental Hygiene. College (1-4 or 5+) Mental Hygiene. Assembly Worker Furniture Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname)
Katherine (unk) Kibler ည Walter McKinley Seal ^{19a.} Informant's Name/Relationship (Type, *Print*) Charlene Lloyd / Case Manager 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 140 W. Franklin Street, Hagerstown, MD 21740 27 is r item 2 20a. Method of Disposition 20b. Place of Disposition (Name of Date 20c. Location - City or Town, State permit. Page 1
Department of Important: If it any injury or o cemetery, crematory or other place)
Cedar Lawn Mem Park 1 🔀 Burial 2 🗆 Cremation 3 🗆 Removal from State 12/30/2009 Hagerstown, MD 4 Donation 5 Other (Specify) 21. Signature of Funeral Service Licenses 22. Name and Address of Facility Gerald N. Minnich Funeral Home 305 N. Potomac Street, Hagerstown, MD 21740 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final Onset and Death Ph sician/ disease or condition resulting in death) Sapr Medical Due to (or as a consequence of): Examiner Sequentially list conditions Examine if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Due to (or as a consequence of): Hospital or Attending Physician: The law requires that the death certificate be executed Rai and use as the burial-tran that initiated events resulting in death) Last Due to (or as a consequence of): the attending physician Physician/Medical Dine Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy for in the past 12 months?
1 ☐ Yes 2 ☐ No Month Day Year Pregnant at time of death 5 Other (specify) 4 ☐ Pregnant a 9 ☐ Unknown 9 Unknown ned by t Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by s been signe should be c 1 Yes 2 No 3 Probably 4 Unknown Anemia 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an certificate has I autopsy performed page 2 2 🗌 No 1 Yes 25. Was case referred to medical examiner?

1 Yes 2 No funeral director, Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital မ 1 Inpatient 2 ER/Outpatient 3 DOA After this 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at Certificate: 28d. Describe how injury occurred 1 4 Natural 5 Pending work? 1 ☐ Yes 2 ☐ No 2 Accident
3 Suicide Investigation after death completed filled in by the 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined City or Town, State) within 24 hours a

To the Funeral C Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check only one) 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month. Dav. Year) 12-11 D18019 DEC 28, 2009

State Registrar

DHMH 17 Rev 7/2009

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gistrar's Signature

MILL ST HAKERSTOWN

MO 21740

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

DATTA

31. Date filed (Month, Day, Year) DEC 29 2009

State of Maryland / Department of Health and Mental Hygiene Certificate of Death Date of Death
 Month 1. Decedent's Name (First, Middle, Last) Day Year Physician 09 telen /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number, 4b. City, Town, or Location of Death Examiner Charleston Retirement Community Baltimore Catonsville If Under 1 Year If Under 24 Hrs.
Months Days Hours Min. 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** Days 1 ☐ M 2 💢 F Yrs. Director 93 151-34-2810 7/6/1916 MD Usual Residence of Decedent death with the Maryland 10c. City, Town or Location 10d. Inside City Limits 10a. State 10b. County If item 27 is marked other than "natural"; or items 23a or 28a-f show or other traumatic event, the Medical Examiner must be notified at 1 ☐ Yes 2 X No Director MD Howard Ellicot City 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 3406 Font Hill Dr. 21042 USA Funeral 14. Race - American Indian. 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Black, White, etc. Pages 1 and 2 should be filed within 72 hours after nent of Health and Mental Hygiene. nt: If item 27 is marked other than "natural"; or ite 1 ☐ Yes 2 🛣 No If Yes, Give Year or Dates: 1 Never Married 2 Married 1 ☐ Yes 2 X No Specify: Specify: Completed by 3 ₩Widowed 4 Divorced white 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) 12 Registered Nurse Health Care 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be 2 Harry Deputy Rhetta Warfield 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 3406 Font Hill Dr. Ellicot City, MD 21042 Paul Shepherd/Son 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 Burial 2 ☐ Cremation 3 ☐ Removal from State permit. Page Department o Important: If any Injury or 4 ☐ Donation 5 ☐ Other (Specify) Paul's 12/24/09 Chestertown, MD 21. Signature of Funeral Service Licens 22 Name and Address of Facility Fellows, Helfenbein & Newnam Funeral Home 130 Speer Rd. Chestertown, MD 21620 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** Fschemic /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner Physician: The law requires that the death certificate be executed burial-tran Due to (or as a consequence of): attending physician Physician/Medical as the use 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy for Month Day Year in the past 12 months? 4 ☐ Pregnant at time of death 5 ☐ Other (specify) 1 Yes 2 No detached 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4₽ Onknown Completed 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☐ No 24a. Was an has page 2 autopsy performed? certificate 1□ Yes 2 2 No 25. Was case referred to medical examiner? director. Be 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 ☑ No 1 Inpatient 2 ER/Outpatient 3 DOA Certification: To this completely filled in by the funeral 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Hospital or Attending 5 ☐ Pending investigation 1 Natural 1 ☐ Yes 2 ☐ No death. 2 Accident 24 hours after death e Funeral Director: 6 ☐ Could not be 3 Suicide Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 ☐ Homicide 1 🗹 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) within 2 and manner stated. the 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier ၉ 24437 21225 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) oice Lane, Cotonsville, Marclen Bowlin 711 31. Date filed (Month, Day, Year) 32. Registrar's Signature State Registrar

DHMH 17 Rev 1/2001

Baltimore, Maryland 21215-0036

Division or Vital Records, P.O. Box 68760,

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar 12–28–09Amend#31.PerVRPGCcr Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Month **Physician** Sharon 2:36 P^M Kay Smith 2009 December 21 /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death **Examiner** 7204 Hanover Parkway Greenbelt Prince George's 5. Social Security Number If Under 1 Year | If Under 24 Hrs. Date of Birth (Month, Day, Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) **Funeral** 1 M M Months Days Hours 558-76-9177 57 Director Oct.8,1952 <u>Kansas</u> Usual Residence of Decedent death with the Maryland 10d. Inside City Limits 10a. State 10b. County 10c. City, Town or Location Director 1X Yes 2 □ No ral", or items 23a or 28a-f st Examiner must be notified Maryland Prince Georges Greenbelt 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 7204 Hanover Parkway U.S.A. 20770 Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 Tyes 2 No Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. Pages 1 and 2 should be filed within 72 hours after inent of Health and Mental Hygiene. int: If item 27 is marked other than "natural", or ite 1 ☐ Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2X No White þ If Yes, Give Specify: 3 ☐ Widowed 4X Divorced Year or Dates: Completed injury or other traumatic event, It e Medical 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry Decedent's Education (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) Data Entry Operator Private 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Thomas Dossett Rilda Moser 2 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Jordan Dossett (Daughter) 7311 Baylor Avenue, College Park, MD 20740 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition permit. Pages 1 Department of H Important: If ite any injury or ot once. 1 ☐ Burial 2 X Cremation 3 ☐ Removal from State Chesapeake Crematory 12/24/2009 Beltsville, MD 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility 21. Signature of Funeral Service License Rendon/Hale Funeral Home unore 9013 Annapolis Rd. Lanham, MD 20706 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** han /Medical ue to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner and burial-trar Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, ed by the attending physician detached for use as the buria Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 4 ☐ Pregnant at time of death 9 ☐ Unknown 23b. Was decedent pregnant 23d, Date of delivery 3 🗆 Ectopic pregnancy in the past 12 months? 1 □Yes 2 □No Month Year 5 Other (specify) Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? <u>Ş</u> 1 ☐ Yes 2 ☐ No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? Yes 2 No 2 No 1 □ Yes 1 Yes spital or Attending Physician; Thours after death. neral Director: After this certificate filled in by the funeral director, pa 25. Was case referred to medical Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Presidence 6 Other (Specify) 1 Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA Certification: To 28a. Date of Injury (Month, Day, Year) 27. Manner of Death 1 Natural 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 5 ☐ Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide To the Hospital or within 24 hours af To the Funeral D 🛮 🗹 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year)

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State Registrar

31. Date filed (Month, Day,

DHMH 17 Rev 1/2001

anham

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

	•	1- For State of Maryland /	Depa	artment tificate	of H	ealth a	nd M	R	eg. No.	2009	4286
Physicia /Medic Examin	al	1. Decedent's Name (First, Middle, Last) Charito 4a. Facility Name (If not institution, give street and number) The Johns Hopkins Hospital	,	Santa 4b. City, 1 Baltin	lown, or	Location of		2. Date of Dear Month December	Day 22	Year 2009 punty of Death	3. Time of Death
Funeral Director	3	5. Social Security Number 6. Sex 7. Age (In yrs. last b 558-73-1482 54 54	oirthday) Yrs.	If Under Months		If Under 2 Hours	24 Hrs. Min.	8. Date of Birth (Month, Day)	, 1955	9. Birth	nplace (State or Foreigr ntry) ippines
filed within 72 hours after death with the Maryland Hygiene. wher than "natural", or items 23a or 28a-f show ent, the Medical Examiner must be notified at	Director	Usual Residence of Decedent 10a. State 10b. County Maryland Prince Georges Fort 10e. Street and Number 12524 Monterrey Circle			Code			1		n of What Cou	
The Pages 1 and 2 should be filed within 72 hours after death with the Marylan aritment of Health and Mental Hygiene. ordant: If Item 27 is marked other than "natural", or items 23a or 28a-f show injury or other traumatic event, the Medical Examiner must be notified at e.	ed by Funeral Director	11. Marital Status 1 □ Never Married 2 □ Married 3 □ Widowed 4 ☑ Divorced 12. Was Decedent Ever in U.S. Armed Forces? 1 □ Yes 2 ☑ No If Yes, Give Year or Dates:			ent of Hi ify Cubar	Specify:	in? (Spe Puerto F	cify Yes or No- Rican, etc.)	14.	Race - Amer Black, White	ican Indian, , etc. lipino
d 2 should be filled within 72 hours aft th and Mental Hygene. This marked other than "natural", or traumatic event, the Medical Examit	Be Completed	(Specify only highest grade completed) Elementary/Secondary (0-12) 12 College (1-4 or 5+) 4 17. Father's Name (First, Middle, Last)	(Give life. L	kind of wor DO NOT us Ne Nur	k done c e retired)	luring most	r's Name	e (First, Middle,	Seac	rest I	
and 2 should be filed within ealth and Mental Hygiene. n 27 is marked other than ler traumatic event, the Me	TO B			•	•	and Numbe	r or Rura	e Ramos	r, City or T		ip Code) MD 20744
permit. Pages 1 and 2 Department of Health Important: If item 27 i any injury or other tra once.		Marietta Atienza (Sister(20a. Method of Disposition Burial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify)	of Dieno	sition (Nam	ne of		D	lato	20c Loca	tion - City or ina Ci ppines	Town State
permit. Pages 1 Department of I Important: If ite any injury or ot		21. Signature of Funeral Service Licensee 21. A genden 23a. P. 1. Enter the disease, complications that caused the death. Do			Anna	apoli	s Rd	ndon/Ha . Lanha	m, MI		
Physician personed / Medical Examiner physician and physician and sa the prial-transit	lical Examiner	Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last a. Drimary bill Due to (or as consequence or consequenc	be of): be of): inal		rial			nitis			Onset and Death
certifica nding ph use as th	Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal dea 4 ☐ Pregnant at time of death		☐ Ectopic p		,			236	d. Date of del Month	ivery Day Year
ie law requires that the death has been signed by the atter ge 2 should be detached for	Completed by P	Part II. Other significant conditions continuuting to death but not resulting	g in the u	underlying (cause giv	ven in Part	I. 	23e. Did to	es 2 ≥	No 3 ☐ Pro	o the cause of death? obably 4 \(\subseteq \text{Unknow} \) otopsy findings availab completion of cause of
To the Hospital or Attending Physician: The law requires twithin 24 hours after death. To the Funeral Director: After this certificate has been signe completely filled in by the funeral director, page 2 should be	Certification: To Be	25. Was case referred to medical examiner? 1	b. Time o Injury farm, str	M reet, factory	8c. Injury Work 1 office at the tin	er: 4 Nui y at ? Yes 2 1	No :	1 ☐ Yes (Check only or me 5 ☐ Resid 28d. Describe h 28f. Location (S City or Town and due to the	ence 6 ow injury of treet and n, State)	1 Yes Other (Special Special	ural Route Number,
To the Ho within 24 To the Fu complete	Medical	Voanna M. Peloguen		290	. License	number			29d. Date :	signed (Monti	
3 Sta Registr		30. Name and address of person who completed cause of death (Item 23: 2009) 31. Date filed (Month, Day, Year) DEC 2 8 2009					600 1	North Wo	lfe St,	Baltimo	ore, MD, 2128

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Sequentially list conditions if any, leading to immediate cause. Enter Underlying Cause (ause. Enter Underlying Cause) Part 1 1 2 2 2 2 2 2 2 2			Immediate Cause (Final disease a. Atherosclerotic Cardiovasc	cular Disease			Death
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24a. Was an autopsy performed? 1	P.O es that t	by	Facility Colleges Significant Conditions	ming in the analying scale grown act	1 Yes	2 No 3 Probably	4 Vnknown
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C is a fact of the course of t	ivisi or Att after de Directo	tifica	3 Suicide 6 Could not be 28e. Place of Injury - At home	e, farm, street, factory, office building, etc.			oute Number, City
2 = 2 2 0 (Check only Check o	D fospital t hours uneral		29a. Certifier	death occurred at the time, date and place, an	d due to the caus	e(s) and manner as stated.	
and manner stated	the the	Medical	one) _ 2 Medical Examiner: On the basis of examination and/	or investigation, in my opinion, death occurred	at the time, date	and place, and due to the cau	se(s)
29c. License number 29d. Date signed (Month, Day, Year)		Me					ay, Year)
() (aluleuu)			(Calaleury)			December 21, 2009	
30. Name and address of person who completed cause of death (Item 23a) Laron Locke MD. Assistant Medical Examiner 111 Penn Street, Baltimore, MD 21201			· · · · · · · · · · · · · · · · · · ·		201		
State 31. Date filed (Month, Day, Year) Registrar DEC 23 2009 32 Registrar's Signature			31. Date filed (Month, Day, Year) 32 Registrar's Signature	ball			

State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Physician Harold Thomas Stewart Jr. December 19 2009 4:15 A M /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner Wicomico Salisbury Wicomico Nursing Home 8. Date of Birth (Month, Day, Year) 06/17/1920 9. Birthplace (State or Foreign If Under 1 Year If Under 24 Hrs. Social Security Number 214–10–9187 7. Age (In yrs. last birthday) **Funeral** Days 1 X M 2 □ F 89 Maryland Director Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location r 28a-f show notified at 10a. State 10b. County 1 ☐ Yes 2 ☐ No Wicomico Salisbury Director Maryland 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number 7 is marked other than "natural", or items 23a or traumatic event, the Medical Examiner must be it 21804 USA 413 S. Kaywood Drive Funeral 14. Race - American Indian, 12. Was Decedent Ever in U.S Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 1 ☐ Yes 2 👿 No If Yes, Give Year or Dates: 1 ☐ Never Married 2 ☐ Married 1 ☐ Yes 2 No Specify: Specify: þ 3 ☑ Widowed 4 ☐ Divorced white Completed 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) worker E.I. DuPont Inc. 12 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ... Pages 1 and 2 should be fill tment of Health and Mental H tant: If item 27 is marked oth Be Harold T. Stewart Margaret P. Cavender 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 328 Cedar Dr., Salisbury, MD 21804 Department of Health a Important: If item 27 is any injury or other tra Lee Smith/nephew Date 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 12/21/09 Salisbury Crematory Salisbury, MD 4 □ Donation 5 □ Other (Specify) H-Funeral Service Licenses 22. Name and Address of Facility Holloway Funeral Home Professional Association 501 Snow Hill Rd., Salisbury, MD 21804 23a Part. Enter the disease, or complications that cause the shock, or heart fallure. List only one cause on each ine death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Immediate Cause (Final disease or condition resulting in death) CARDIONASCULAR THEXISCLERATIC **Physician** /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Due to (or as a consequence of): Examine that initiated events resulting in death) Last burial-trar and Due to (or as a consequence of): physician Physician/Medical ass IF FEMALE: for use 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No 4 ☐ Pregnant at time of death 5 Other (specify) 9 Unknown 9 🗆 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. þ 4 Unknown 1 ☐ Yes 2 ☐ No 3 ☐ Probably page 2 should Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an perform 2 NO 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Be Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 1 No 1 🔲 Inpatient 2 ER/Outpatient 3 DOA this funeral 27. Manne of Death 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 28b. Time of 28d. Describe how injury occurred e Hospital or Attending P 24 hours after death. e Funeral Director: After t Certification: After 5 ☐ Pending investigation 1 v atural 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 Thomicide To the Hospital within 24 hours at To the Funeral L 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 29c. License number 29d, Date signed (Month, Dav. Year) 29b. Signature and title of certifier 109 alunn 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 614 Eastern Shore Drive, Salisbury, MD 21804 Mahesha Thimmarayappa, MD 32. Registrar's Signature

Registrar

State

with the Maryland

death v

5-0036

Baltimore, Maryland 2121

requires that the death certificate be executed

P.O. Box 68760,

Division or Vital Records,

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Rea. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month Dav **Physician** NSYST 16 SCHMPST /Medical 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) **Examiner** The Johns Hopkins Hospital **Baltimore City** If Under 1 Year | If Under 24 Hrs. Months | Davs | Hours | Min. 8. Date of Birth (Month, Day, Year) 5. Social Security Number Birthplace (State or Foreign Country) Age (In vrs. last birthday) **Funeral** Days Hours 1 XM 2 □ F Yrs 38 222-60-2004 Oct. 29, 1971 Delaware Director Usual Residence of Decedent 10a, State 10b. County 10c. City, Town or Location 10d. Inside City Limits ral", or items 23a or 28a-f show Examiner must be notified at 1 ☐ Yes 2XX No Director DE Laurel Sussex 10g. Citizen of What Country? 10e. Street and Number 10f. Zip-Code 19956 U.S.A. 32511 Meadow Branch Drive Funeral death y 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ▼ No If Yes, Give Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian 11. Marital Status Black, White, etc. 72 hours after 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 TX No Specify. Š Specify. 3 Widowed 4 X Divorced Year or Dates white "natural", Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry traumatic event, the Medical 15. Decedent's Education (Specify only highest grade completed) and 2 should be filed within and Mental Hygiene. Is marked other than Elementary/Secondary (0-12) College (1-4 or 5+) Land Surveying Surveyor 12 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Lewis Charles Trivits Roxanne Jones 2 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Department of Health a Important: If Item 27 Is any injury or other trains 32511 Meadow Branch Drive Laurel, DE Roxanne Palmer (Mother) 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a, Method of Disposition Date 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State Odd Fellows Cemetery 12-22-2009 4 ☐ Donation 5 ☐ Other (Specify) Seaford, Delaware 22. Name and Address of Facility Short Funeral Home 21. Signature of Funeral Service License 26 w 19940 13 East Grove Street Delmar, DE 23a. Part 1. Enter the disease shock, or heart failure. s that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between Onset and Death ease, or complication List only Immediate Cause (Final **Physician** 1000 end109 disease or condition resulting in death) /Medical Due to (or as consequence of): Examiner Sequentially list conditions, if any, leading to immediate Cause (Disease or injury Due to (or as a consequence of) Exami The law requires that the death certificate be executed physician and as the burial-trans that initiated events resulting in death) Last Due to (or as a consequence of) Box 68760, Physician/Medical use as the IF FEMALE 23c, If ves. outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant Live birth 2 Fetal death 3 Ectopic pregnancy in the past 12 months? Month Year Pregnant at time of death 5 Other (specify) Yes 2 \(\text{No} the 9 Unknown Division of Vital Records, P.O. 9 Unknown signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I 23e. Did tobacco use contribute to the cause of death? 2 1 Yes 3 Probably 4 Unknown Completed plnous 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy has page 1 1 🗌 Yes 1 Tyes 2 🗌 No 25. Was case referred to medical 26. Place of Death (Check only one Be examiner? Other: 4 \square Nursing Home 5 \square Residence 6 \square Other (Specify) 1 ☐ Yes 2 X No 1 | Inpatient 3 🗆 DOA 2 ER/Outpatient မှ this funeral 27. Manner of Death 28c. Injury at Work? 28d. Describe how injury occurred 28a. Date of Injury (Month, Day Year) 28b. Time of Certification: After or Attending 1 X Natural 5 Pending investigation Injury 1 ☐ Yes 2 ☐ No death. Accident eral Director: A filled in by the f 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 Suicide 6 Could not be 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide hours after 24 hours a To the Hospital 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical

within 2

State Registrar

29b. Signature and title of

31. Date filed (Month, Day, Year) DEC 18

30. Name and andress of person who completed cause of death (Item 23a) (Type, Print)

registrar's Signature

and manner stated.

29d. Date signed (Month, Day, Year)

600 North Wolfe St, Baltimore, MD, 21287

December 16 2009

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)

29c. License number

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death **Physician** Lehman Robert Tomlin, Jr. /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death Examiner Peninsula Regional Medicini Center Salisbury Wicomico If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) 12-14-1935 Birthplace (State or Foreign Country) **Funeral** 1 □ M 2 □ F Months Days Hours Min. Ohio Director 300-30-8097 Usual Residence of Decedent death with the Maryland 10a. State 10c. City, Town or Location 10d. Inside City Limits d other than "natural", or items 23a or 28a-f show event, the Medical Examiner must be notified at 10b. County Director 1 ☐Yes 2 🔀 No Sussex Millsboro DE 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 4201 Caitlin's Way 19966 U.S.A. Funeral 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. 11. Marital Status Armed Forces? IXYes 2 ☐ No Black, White, etc Pages 1 and 2 should be filed within 72 hours after 1 XYes 2 No If Yes, Give Year or Dates: Navy 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2X No Specify: Š 3 Widowed 4 Divorced Black Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) permit. Pages 1 and 2 should be filed within Department of Health and Mental Hygiene. Important: If item 27 Is marked other than 'amy injury or other traumatic event, I'm Me once. Elementary/Secondary (0-12) College (1-4or 5+) United Methodist Pastor Clergy/Pastor 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Willeen Davis Lehman R. Tomlin, Sr. ပ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 4201 Caitlin's Way, Millsboro, DE 19966 Lorraine Tomlin/Wife 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State Slaughter Neck 4 ☐ Donation 5 ☐ Other (Specify) 12-19-2009 Old Hickory Cem Lincoln, DE 21. Signature of Funer I Service Licensee 22. Name and Address of Facility Bennie Smith 917 W. Isabella St. Funeral Home Salisbury, MD 21801 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** INTRACEPEBRAL HEMORPHAGE /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): certificate be executed sician and burial-trans Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, signed by the attending physician d be detached for use as the buria Physician/Medical 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? Month Day Year 4 ☐ Pregnant at time of death 5 Other (specify) 1□Yes 2□No 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use conflibute to the cause of death? Š 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 □ Yes 2 □ No 24a. Was an certificate has autopsy performed? Yes 2 No Physician: 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 Yes 2 No 1 🗂 Inpatient To the Hospital or Attending Phys within 24 hours after death.

To the Funeral Director: After this: completely filled in by the funeral dir Certification: To 2 ER/Outpatient 3 DOA 27. Manner of Death Date of Injury (Month, Day, Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 10 Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be 3 ☐ Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical 29a. Certifier 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) 29c. License number Shall Mucles MD, Ph.D. DECEMBER 137, 2009 D54048 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

TACEK M. MALIK MD PAD, 540 SNOW HILL RD, SALISBURY MO, 21804

State

Registrar

31. Date filed (Month, Day, Year)

DEC 18 2009

32. Registrar's Signature

			Amend I For Amen Registrar	Please tems 10a	Type or Print Prin	int in Bla h, g900, laryland / a-f per	ck/ln Depa	delible delibl	nk. Ens / 18720	oure A	II Copie ental Hy	s Are	e Legible e 200	e. 19 42	2868
			Registrar 1. Decedent's Name (Cert	fificate o	f Death		2. Date of De		o.	3. Time o	of Death
	Physicia Medic		Lo1a	Mae Ting	le						Month	. Da	6 200		52 AM
	Examin		4a. Facility Name (if no	t institution, gives Hospice		lake		4b. City, Town	or Location	of Death		40	County of De		
	Funeral Director		5. Social Security Num 218-20-59	ber 6. Sex		ge (In yrs. last bii		If Under 1 Ye Months Da		Min.	8. Date of Bir (Month, Da Sept. 2	rth ay, Year)	9. E	sirthplace (State Country) Laware	or Foreign
	how at	Ž	Usual Residence of De	ecedent 0b. County		10c. City, Tow	vn or Loca	ation				, _,		10d. Inside C	City Limits
	Marylar 28a-f s otified	Director	DE MD	Wicomi Sussex			mar	Salish	ury						s 2 ⊠ N o
	should be filed within 72 hours after death with the Mayland and Mental Hygiene. and Mental Hygiene. is marked other than "natural", or items 23a or 28a-f show aumatic event, the Medical Examiner must be notified at	Funeral D	10e. Street and Number 36784 Rob	er 415 Tro in Hood	opers War Road	У		10f. Zip Cod	e 40 21	.804		-	itizen of What (Country?	
(0	er death or items niner m	by Fun	11. Marital Status 1 Never Married		12. Was Decedent Armed Forces? 1 ☐ Yes 2 🛣		If	as Decedent of Yes, specify C	uban, Mexicar	n, Puerto F	cify Yes or No- Rican, etc.)		14. Race - An Black, Wh	nerican Indian, iite, etc.	
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	ed with Hygien other tl ent, the	Be	12 17. Father's Name (Firs	st, Middle, Last)			Са	shier	18. Moth	er's Name	(First, Middle,			Company	7
Maryland	ld be fil Mental arked atic ev	욘	Littleton	Frankli	n Taylor				1		C. Hi				
Mar	42 ₹ 2		19a. Informant's Name Patricia		_{e, Print)} Daughter)			Address (Stre			Route Number		r Town, State, . DE 199		
Baltimore,	ge 1 and it of Heal if item :		20a. Method of Dispos	ition	Removal from State	20b. Place	of Dispos	ition (Name of		D	ate	20c. L	ocation - City		-
altim	permit. Page 1 Department of Important: If i any injury or once.		4 ☐ Donation 5 21. Signature of Funer	Other (Specify)	e _	Spring	ghi11 22.	Memor Name and Ad	y Gardo dress of Facilit	ens ty	200.	Heb		aryland	
ĕ	any any		Grups	Sherts	Vewell	_		Name and Ad Short F 3 East					, DE	19940	
	nysician/		Immediate Cause (Fin	ailure. List only one	e cause on each lin	d the death. Do e. ムルンT		the mode of o	lying, such as	cardiac or	respiratory ar	rrest,		Approxima Interval Be Onset and	tween
	Medical Examiner		disease or condition resulting in death)	C.	Due to (or as	a consequence	of):	./-					.7		
		iner	Sequentially list conditions, leading to immediately.	itions, t		>URAL		HAM.	A 10 M	0	11 /	12	VAMINER		
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Box 68760	death certificate be executed the attending physician and ed for use as the burial-transition.	Physician/Medica	IF FEMALE: 23b. Was decedent pro in the past 12 mp	nths?		of pregnancy 2 Fetal dear at time of death		Ectopic pregr					23d. Date of o	lelivery Day	Year
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JS, P.	uires the in signec uld be d	ed by	Part II. Other significa	in conditions con		out not resulting	in the an		giveniirait		1 🗆		1	Probably 4	
Vital Records,	sician: The law requires that the descentificate has been signed by the rector, page 2 should be detached	Completed									24a, Was auto	psy	prior t	autopsy findings completion of	
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	rnysici this cer al direc	은	examiner? 1 X Yes 2/11	10	ospital: 1 Inpat 28a. Date of inju	ient 2 ER/O	outpatient Time of	3 L DOA					Other (Sp.	ecify) Hos	P142
o uo	ending sath. or: After he funer	Certificate:	Natural 8	Pending Investigation	Found ^{th, Da} 12/06/20	ry, Year) Fo u	ind:	a. 📗 🤈	ijury at ork? ☐ Yes 2 X	No	8d. Describe I Probab	le f	a11		
Division of	al or Attus s after de al Directo d in by t		∫3 ☐ Suicide € 4 ☐ Homicide	6 U Could not be determined	28e. Place of Inj building, et Found:					y 2	8f. Location (City or Tov	Street an wn, State alis	Number or F Found: Soury, M	28965	Log
_	to the hospital of Attending Physician: within 24 hours affect death. To the Funeral Director: After this certific completed filled in by the funeral director,	Medical	(Check 2	Medical Examin	cian: To the best of er: On the basis of e Practioner: To the	examination and/	or investi	gation, in my o	oinion, death o	place, and ccurred at t	due to the ca	ause(s) ar and place	nd manner as s	stated. e cause(s) and m	anner stated.
	within comp	_	29b. Signature and title				3,7	29c. Lice	ense number				ate signed (Mor		
	Sin		30. Name and address	of person who co	mpleted cause of c	death (Item 23a)	(Type, Pri	int)	0052 SAU	111	MA	no	7.16	202	
H	Stat Registra		31. Date filed (Month, L	Day, Year) C 18 200	4	rar's Signature	Sa	A)	3 62 6 2	500	7		VIC		

09 Ha

-10154 iley Thurston	Please Type or Print in Black Inc State of Maryland / Depar			_		
	1- For State Registrar Cert	tificate of Death	na wentar riygiene	Reg. No. 2009 4281		
Physician/ edical Examiner	1 Decedent's Name (First, Middle,Last) Hailey Alexis Thurston		2. Date of D Month Decemb	Death Year OB10 hrs OB10 hrs		
	Facility Name (if not institution, give street and number) Holy Cross Hospital	4b. City, Town, Silver Spri	or Location of Death ing	4c. County of Death Montgomery		
Funeral Director	5. Social Security Number 6. Sex 7. Age (In yrs. last 1 M 2 K F	Months Da	ays Hours Min.	Birth (MM/DD/YYYY) 9. Birthplace (State or Foreign h 24, 2009 Country) MD		
r death with the Maryland or items 23a or 28a-f show any must be notified at once.	Maryland Montgomery	Town or Location Silver Spring		10d. Inside City Limit		
th the Marylanc 23a or 28a-f sh notified at onc	10e. Street and Number 2927 Weisman Road	10f. Zip Code	02	10g. Citizen of What Country? USA		
	11. Marital Status 1 X Never Married 2 Married 3 Widowed 4 Divorced of Parks: 12. Was Decedent Ever in U.S Armed Forces? 1 Yes 2 No If Yes, Give Year On Dates:	If Yes, specify Cuba	dispanic Origin? (Specify Yes or I an, Mexican, Puerto Rican, etc.) lo specify:	No- 14. Race - American Indian, 8lack, White, etc. Specify: White		
36 in 72 hour han "natu lical Exan pleted	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5+)	16a. Decedent's Usual Occup during most of working lif None	ation (Give kind of work done fe. DO NOT use retired)	16b. Kind of Business/Industry N/A		
	17. Father's Name (First, Middle, Last) William Thurston	-	18.Mother's Name (First, Middle Dawn Brigham			
MD d 2 shot lth and l lth	19a. Informant's Name/Relationship (Type, Print) Dawn Nester/Mother	19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 2927 Weisman Road, Silver Spring, MD 20902				
Pages 1 nent of H ant: If i	1 X Burial 2 Cremation 3 Removal from State Gat 4 Donation 5 Other Specify:	ace of Disposition (Name of co ematory or other place) te of Heaven emetery	Dec. 31, 2009	Silver Spring, Marylar		
Balt permit. Departi Importinjury	21. Signature of Funeral Service Licenses		ss of Facility Collins Funera	al Home Inc.		

Physician
Jide chend
Examiner

29b. Signature and title of certifier

31. Date filed Mosth, Dev Yea 2010

Ana Rubio MD

within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial - transit To the Hospital or Attending Physician: The law requires that the death certificate be executed Division of Vital Records, P.O. Box 68760,

Medical Certification: To Be Completed by Physician/Medical Examiner

failure. List only one cause on	each line.	ic or dying, such as cardiac (or respiratory arrest, shock, or rieart	Between Onset and
Immediate Cause (Final disease or condition resulting in death)	a. Complications of lessen Due to (or as a consequence of):	cephaly		Death
Sequentially list conditions, if any, leading to immediate cause. Enter Underlyin, Cause (Disease or injury that initiated events resulting in death). Last	Due to (or as a consequence of): Due to (or as a consequence of):			
X UNPENDED	AMENDED 23a,27,permE, g901	3/8/10 TT		
IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 Yes 2 ✓ No 9 Unknow	1 Live birth 2 Fetal deat 4 Pregnant at time of death 5 Other (St	th 3 Ectopic pregna	23d. Date of deliver	/ Day Year
Part II. Other significant condition:	contributing to death but not resulting in the underlying	ng cause given in Part I.	23e. Did tobacco use contribute to	
				topsy findings available completion of cause of
25. Was case referred to medical		26.Place of Death (Check	only one)	
examiner? 1 ✓ Yes 2 No	Hospital: 1 Inpatient 2 🗸 ER/Outpatient 3	DOA Other Nursin	ng Home 5 Residence 6 Other	
27. Manner of Death 1 X Natural 5 Pending 2 Accident Investiga	28a. Date of Injury (Month, Day,Year) 28b. Time of Injury	28c. Injury at Work?	28d. Describe how injury occurred	
3 Suicide 6 Could no determin	t be 28e. Place of Injury - At home, farm, street, factor	ry, office building, etc.	28f. Location (Street and Number or Ru or Town, State)	ral Route Number, City

Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 📝 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)

29c. License number

O.C.M.E.

111 Penn Street, Baltimore, MD 21201

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart

Inc. Spring,

29d. Date signed (Month, Day, Year)

December 29, 2009

Approximate Interval

22 Name and Address of Facility Francis J. Collins Funeral Home 500 University Blvd. W., Silver

State

Registrar

30. Name and address of person who completed cause of death (Item 23a)

and manner stated

Assistant Medical Examiner

2. Registrar's Signature

alles.

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Carroll Townsend 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death alisbur come yes ag 8. Date of Birth (Month, Day, Year) 05/01/1932 If Under 1 Year | If Under 24 Hrs Birthplace (State or Foreign Country) Maryland 5. Social Security Number Age (In yrs. last birthday) Days Months 1 X M 2 □ F 215-26-6179 77 Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10a, State 10b. County Wicomico Salisbury Maryland 1XYes 2∏No 10f. Zip Code 21804 10g. Citizen of What Country? 10e. Street and Number USA 1011 Schumaker Drive 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, 11. Marital Status Black White etc. 1 Tres 2 No If Yes, Given irForce Year or Date irForce 1 Never Married 2 Married 1 ☐ Yes 2 █No Specify: Specify: white 3 Widowed 4 X Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) truck driver Trucking 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Ida Mae White Carroll Townsend 19a. Informant's Name/Relationship (Type. Print) C.J. Townsend/son Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1128 Riden Ct., Salisbury, MD 21804 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition 1 ☐ Burial 2 X Cremation 3 ☐ Removal from State 12/21/09 4 □ Donation 5 □ Other (Specify) Salisbury, MD Salisbury Crematory AdTroway Funeral Home Professional Association 501 Snow Hill Rd., Salisbury, MD 21804 23a Part 1. Enter the disease, or complications that cause shock, or heart failure. List only one cause on each Approximate Interval Between Onset and Death the death. Do not enter the mode of dying, such as cardiac or respiratory arrest Immediate Cause (Final disease or condition resulting in death) Due to (or as a consequence of): Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Due to (or as a consequence of): that initiated events resulting in death) Last Due to (or as a consequence of) 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 5 Other (specify) 9 I Linknown 23e. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 1 ☐ Yes 2 ☐ No 24a. Was an 1 ☐ Yes 26 Place of Death (Check only one. Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 ER/Outpatient 3 DOA 1 Inpatient

Physician /Medical Examiner

Physician

/Medical

Examiner

Funeral

Director

r than "natural", or items 23a or 28a-f show the Medical Example, must be notified at

is marked other

permit. Pages 1 and 2 s Department of Health ar Important: If item 27 is any Injury or other trau once.

Pages 1 and 2 should be 1 nent of Health and Mental

21215-0036

Baltimore, Maryland

Director

by Funeral

Completed

Be

Examiner

the Hospital or Attending Physician: The law requires that the death certificate be executed burial-tra attending physician as the l for use ned by the signed | I be det funeral director, page 2 should this

Division of Vital Records, P.O. Box 68760,

Physician/Medical 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. ģ Be Completed 25. Was case referred to medical examiner? 1 ☐ Yes Medical Certification: To 28a. Date of Injury (Month, Day, Year) 28b. Time of Injury 28c. Injury at Work? 27. Manner of eath Natural 5 Pending 1 ☐ Yes 2 ☐ No 2 Accident investigation 6 Could not be determined 3 Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 ☐ Homicide

28d. Describe how injury occurred

28f. Location (Street and Number or Rural Route Number, City or Town, State)

Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year)

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

hin 24 hours after death. the Funeral Director: A

completely filled in by the

29a. Certifier (Check only one)

Amended Item Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

18 per F.D. 12/23/2009 Carroll County, will State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrat Certificate of Death Reg. No. 2 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month Day Physician Patricia Helen Williamson Dec 16, 2009 1447 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Death **Examiner** Carrol1 Carroll Hospice Dove House Westminster 8. Date of Birth (Month, Day, Year) If Under 1 Year | If Under 24 Hrs. Birthplace (State or Foreign Country) 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** Months Days Hours Min. 1 □ M 2√2 F 79 Director 212-26-5976 Jan 4, 1930 Maryland Usual Residence of Decedent be filed within 72 hours after death with the Maryland 10c. City, Town or Location 10b. County 10d. Inside City Limits show 10a. State 7 is marked other than "natural", or items 23a or 28a-f show traumatic event, the Madical Experiment is sail be rectified at 1 ☐ Yes 2X No Director Westminster Maryland | Carroll 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 507 High Acre Dr 21157 USA Funeral Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces?

1 Yes 2 No 14. Bace - American Indian. 11. Marital Status Black, White, etc. 1 ☐ Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 If Yes, Give Year or Dates: 1 ☐ Yes 2 TNo Specify. \$ Specify: 3 Widowed 4 Divorced White Completed 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) State of Maryland and Mental Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) Secretary Vocational Rehab 12 17. Father's Name (First, Middle, Last) ¹⁸ Mother's Name (First, Middle, Maiden Surname) Maryanna Toma Lovitz McMechen Be Marie Toma William Wallace McMechen မ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Pages 1 and 2 sh Department of Health and Important: If item 27 is n any Injury or other traun once. <u>Kathy Lawhon - Daughter</u> 903 Coach Way Annapolis, MD 21401 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State Date 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Carroll Cremation Inc 12/18/2009 | Hampstead, Maryland Signature of Funeral Service Licenses 22. Name and Address of FacilityPritts Funeral Home & Chapel, PA KA 412 Washington Rd. Westminster, MD 21157 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** CANCER -UNG disease or condition resulting in death) /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to (or as a consequence of) requires that the death certificate be executed and the burial-tran Due to (or as a consequence of): Box 68760. attending physician Physician/Medical use as IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy ģ in the past 12 months?
1 □Yes 2 ☑ No Month Year 5 Other (specify) P.0. the detached 9 Unknown 9 Unknown cate has been signed by page 2 should be detach 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Division of Vital Records, ģ 3 Probably 4 ☐ Unknown 1 ☐ Yes 2 ☐ No Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed certificate 1 ∐Yes 2 🗷 No 2 **Z**No 1 ☐ Yes Physician: director, 25. Was case referred to medical Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To After this funeral d 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Hospital or Attending 5 ☐ Pending investigation 1. Natural Injury 1 ☐ Yes 2 ☐ No within 24 hours after death.

To the Funeral Director; A 2 Accident the 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 Homicide 29a. Certific Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical юmpletely Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29c. License number 29d. Date signed (Month, Day, Year) 29b. Sign certifier 12/18/09 of person who completed cause of death (Item 23a) (Type, Print) 32. Registrar's Signature 31. Date filed (Month. Day. Year) State DEC 18 2009 Registrar

State of Maryland / Department of Health and Mental Hygiene 1 - State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death **Physician** Joseph R. Webster 12 26 2009 $3:30p^{M}$ /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Union Hospital E1kton Cecil 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. Birthplace (State or Foreign Country) 8. Date of Birth (Month, Day, Year) **Funeral** 1√ M 2□ F Months Days Hours Min. 82 Yrs. 202-18-8106 **Director** 4/11/1928 PA Usual Residence of Decedent permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural" ~ 3.0.000 any injury or other traumatic event. 10c. City, Town or Location 10b. County 10d. Inside City Limits 10a. State Director 1 ☐ Yes 2 ☑ No MD Cecil Chesapeake City 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 76B Hollywood Beach Rd. 21915 USA Funeral 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. Armed Forces?

1 Tiges 2 No
If Yes, Give
Year or Dates; 1 Never Married 2 Married 1 □Yes 2 □XNo \$ Specify Specify: white 3 Widowed 4 Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Machine Operator Paper Manufacturing 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Joseph A. Webster ဥ Thelma Reed 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Marlene Webster/ wife 76B Hollywood Beach Rd. Chesapeake City, MD 21915 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 12/30/09 1 ☐ Burial 2X Cremation 3 ☐ Removal from State Foard Funeral Home, P.A. 4 ☐ Donation 5 ☐ Other (Specify) Rising Sun, MD 21. Signature of Funeral S 22. Name and Address of Facility R.T. Foard Funeral Home, P.A.
P.O. Box 27 Chesapeake City,
shock or heart failure. List only one cause on each line. MD 21915 Approximate Interval Between Onset and Death Immediate Cause (Final Myscardial Infarction Physician disease or condition resulting in death) /Medical Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Examiner Due to (or as a consequence of) or Attending Physician: The law requires that the death certificate be executed attending physician and for use as the burial-trar resulting in death) Last Due to (or as a consequence of): P.O. Box 68760, Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death
9 ☐ Unknown 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months?
1 ☐ Yes 2 ☐ No 3 Ectopic pregnancy Month Year Day 5 ☐ Other (specify) signed by the a d be detached for 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, Completed by 1 ✓ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a, Was an cate has l autopsy performed rmed? 2 No After this certificate funeral director, pag 1 ☐ Yes 1 □ Yes 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: 1 Yes 2 No Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Medical Certification: To 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred To the Hospital or Attending within 24 hours after death.

To the Funeral Director: Afte completely filled in by the fun 5 ☐ Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier (Check only one) 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier D0023322 Serohder SMD 12.28.2009. 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) S. S SACHDEV MD, 126 A, E High S 126 A, E High St, Elbton MD 21921. SACHDEN MD, 32. Registrar's Signature Day, Year) State Registrar

DHMH 17 Rev 1/2001

Funeral Director

Be Completed by

2

Physician

/Medical

Examiner

Funeral

Director

/Medical

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Registrar 1. Decedent's Name (First, Middle, Last)		imouto or	<i></i>	2. Date of Deat	eg. No. 20	3. Time of Death
Bonnie Lee Wagner				Month DECEMBER		Gear 5:57PM
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Western Maryland Hospital		Hageı	rstown		Washi	.ngton
5. Social Security Number 6. Sex 7. Ag	ge (In yrs. last birthday)	If Under 1 Year Months Days				9. Birthplace (State or Foreign
212–50–7776	61 Yrs.	World's Days	Flours Will.	May 29,		Maryland
Usual Residence of Decedent 10a. State 10b. County	10c. City, Town or Lo	ocation				10d. Inside City Limits
Maryland Frederick	Monrovi	a				1 □Yes ¾ No
10e. Street and Number		10f. Zip Code		10	Og. Citizen of Wh	nat Country?
4011 Lynn Burke Road		217	770		USA	
11. Marital Status 12. Was Decedent Armed Forces?	Ever in U.S. 13.	Was Decedent of H	lispanic Origin? (S	Specify Yes or No-		American Indian, White, etc.
1 Never Married 2 Married 1 Yes 2 1 If Yes. Give	No	1 ☐ Yes 2 🛣 No	Specify:	no moan, etc.)	Specify:	white
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Elementary/Secondary (0-12) College (1-4or	5+)	DO NOT use retired	a)		Or 1-	mo
17. Father's Name (First, Middle, Last)	Ноше	emaker	18 Mother's No	me (First, Middle, N	Own ho	
George E. Sier, Sr.		:		me (First, Middle, N : Kline	raideri Surname,	
19a. Informant's Name/Relationship (Type. Print)	40h Marilla	Add (04			0" T 0	
Tammy Carter - daughter				Tural Route Number, [1]amsvi1]	•	
Oa. Method of Disposition	20b. Place of Dispo	sition (Name of	<u> </u>	Date	20c Location - C	ity or Town, State
		matory or other plac	ce)	Date	-00. 20044011 0	
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Physician/Medical Examiner in the past 9 ☐ Unkno Part II. Other si Medical Certification: To Be Completed by END-CHROI 25. Was case re examiner? 1 ☐ Yes 27. Manner of D 1.XNatural 2 Accider 3 ☐ Suicide 4 Homicia 29a. Certifier (Check only one) and manner stated

29c. License number

D0062895

1500 Pennsylvania Avenue

21742

29d. Date signed (Month, Day, Year)

DECEMBER, 15, 2009

State Registrar 31. Date filed (Month, Day,

29b. Signature and title of certifier

32. Registrar's Signature

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Hagerstown, MD antid

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		Dii	re	ct	o
Itimore, Maryland 21215-0036	n 72 hours after death with the Maryland		rtant: If item 27 is marked other than "natural", or items 23a or 28a-f show	njury or other traumatic event, the Medical Examiner must be notified at	

1. Decedent's Name (First, Middle, Last) Day Year cian 17:00 PM 2009 10 moles ica 4a. Facility Name (If not Institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death iner Anne oad dou If Under 24 Hrs. 8. Date of Birth (Month, Day, Birthplace (State or Foreign Country) 5. Social Security Number Age (In yrs. last birthday) If Under 1 Year Year Days Min 1883 1 M 2 F Yrs 212-30. Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Yes 2 No Director 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? ILSA Radow 2/65 Be Completed by Funeral 14. Race - American Indian, 12. Was Decedent Ever in U.S Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Black, White, etc. 1 ☐ Yes 2 No If Yes, Give Year or Dates: 1 Never Married 2 Married 1 ☐ Yes 2 No Black 3 Nidowed 4 Divorced 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Homema 21 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Montgome ဂ္ a 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Stanford MD 36 0 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 1 ■Burial 2 □ Cremation 3 ☐Removal from State racelawn Gardens 4 Donation 5 Dother (Specify) 121 0 21. Signature of Funeral Service Licensee 22. Name and Address of Facility permi Depa Impo any ir Bennie Smith 5+ mmie 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** CAO (Coronny Artury /Medical Due to (or as a consequence of): Examiner Mellis PLABOTES Sequentially list conditions, if any leading to introduct cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to for as a consequence of Examiner law requires that the death certificate be executed burial-transit Due to (or as a consequence of): Division or Vital Records, P.O. Box 68760, physician Physician/Medical IF FEMALE: for use 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 4☐Pregnant at time of death 5 Other (specify) detached 9□ Unknown 9 Unknown cate has been signed by I page 2 should be detach Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 Yes 2 No 3 Probably 4 Unknown 24a. Was an autopsy performed? 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No Physician: The certificate 1 2 No funeral director. Be 25. Was case referred to medical 26. Place of Death (Check only one) Other: 4 ☐ Nursing Home 5 Markesidence 6 ☐ Other (Specify) Certification: To 1 ☐ Yes 2 No 2 ER/Outpatient 3 DOA 1 ☐ Inpatient After this 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Hospital or Attending 5 Pending investigation 1 Natural Injury 1 ☐ Yes 2 ☐ No death. 2 Accident within 24 hours after death To the Funeral Director: 6 Could not be determined 3 Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 Homicide 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. completely 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) J. Villery 121 2 no 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 2540 The Rom JEFFRON 31. Date filed (Month, Day, Year) 32. Registrar's Signature

State

Registrar

DEC 1

Michelle Watkin		State of Maryland 1- For State Registrar		artment of tificate of		Mental Hy		g. No. 200	9 42875
Physici Medical Exam		1. Decedent's Name (First, Middle,Last) Michelle Watkins					 Date of Death Month December 	Day Year	3. Time of Death 1940 hrs
		4a. Facility Name (if not institution, give street and number Ft. Washington Hospital)		Fort Washing			4c. County of De Prince Geo	
Funeral Director		5. Social Security Number 6. Sex 7. Apr 1 - 2493 1 M 2 F	ge (In yrs. la 39	ast birthday) Yrs	If Under 1 Year Months Days	If Under 24Hrs. Hours Min.	8. Date of Birth	0, 1970 F°	Birthplace (State or reign Washington Country)
yland -f show any once,	tor	Usual Residence of Decedent 10a, State 10b, County Maryland Prince Georges		Town or Locati	ngton				10d. Inside City Limits 1 Yes 2 No
th the Maryland 23a or 28a-f sho notified at once.	Director	10e. Street and Number 114 Aragona Dr.				10f. Zip Code 20744			ountry? tates
after death wi al", or items iner must be	by Funeral	3 Widowed 4 Divorced If Yes, Give Year or Dates:	? x No	1	s Decedent of Hispa es, specify Cuban, M	Mexican, Puerto F	Rican, etc.)	White, etc	nerican Indian, Black, : ack
5-0036 led within 72 hours Hygiene. other than "natur the Medical Exam	Completed	15. Decedent's Education (Specify only highest grade cor Elementary/Secondary (0-12) College (1-4 or 12)		during mo	's Usual Occupation st of working life. Do	O NOT use retire	ork done ed)	16b. Kind of Busine:	,
121 l be fi ental l wrked vent,	To Be Co	17. Father's Name (First, Middle, Last) Michael Anthony 19a. Informant's Name/Relationship (Type, Print)		10h Mailing		Mother's Name (Brenda	A. Wins	,	7.0.1
MD 2 and 2 shot alth and 1 m 27 is 1	۲	Herman Watkins / Spouse		114 A	ragona Di	Ft. W	ashingt	on, Md.	20744
Baltimore, MD 2: permit. Pages I and 2 should Department of Health and M Important: If item 27 is mainjury or other traumatic c		20a Method of Disposition 1 Burial 2 Cremation 3 Removal from St 4 Donation 5 Othe Specify:	ate Cr	rematory or oth	emorial	1/7	/2010	20c. Location - City Landove	r, Md.
Ball permit Depart Impor injury		21. Signature of Funeral Syrvice Licensee						estville,	Md. 20747
Physician /Medical Examiner		23a. Par I. Enter the disease, or complications that caused failure. List only one cause on each line. Immediate Cause (Final disease a. Cardia		Do not enter the		ch as cardiac or i	respiratory arres	st, shock, or heart	Approximate Interval Between Onset and Death
)	_	or condition resulting in death) Due to (or as a consorting to a consorting to b). Due to (or as a consorting to b). Myocard	ial f	ibrosis					
d sit	Examiner	if any, leading to immediate causa Enter Under hing Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a conse							
50, te be executed nysician and burial - transit	MENDED PI line a-b, 27, per ME g900 2/5/10 TT								
ox 687 (ath certifical attending plants as the	sician/N	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 Yes 2 No 9 V Unknown 23c. If yes, outcon 1 Live birth 4 Pregnant at 9 Unknown	ne or pregna	ancy 2 Feta		Ectopic pregnanc		23d. Date of delive Month	ery Day Year
ires that the signed by the detached	d by Phy	Part II. Other significant conditions contributing to death	but not res	sulting in the un	derlying cause give	n in Part I.			to the cause of death?
of Vital Records, ig Physician: The law require this certificate has been sineral director, page 2 should be	Completed						24a. Was an autopsy perform	prior to	
Vital Recognized Brain The this certificate I director, page	To Be	25. Was case referred to medical examiner? 1 Yes 2 No Hospital: 1 Inpatie	nt 2 🗸 E	R/Outpatient		Death (Check on		esidence 6 Oth	
sion of trending Pl death. ctor: After y the funera		27. Manner of Death 1 X Natural 2 Pending Accident Pending Investigation		28b. Time of Inj	ury 28c. Injury a	_	8d. Describe hov	w injury occurred	
Division To the Hospital or Attendia within 24 hours after death. To the Funeral Director: A completely filled in by the fu	Certification:	4 Homicide determined (Specify)			factory, office build		or Town, Stat	te)	Rural Route Number, City
To the Hospital within 24 hours To the Funeral completely filled	edica	one) 2 Medical Examiner: On the basis of exam	knowledge nination and	e, death occurre	d at the time, date a	and place, and duath occurred at the	ue to the cause(s	s) and manner as sta d place, and due to	ated. the cause(s)
	Σ	29b. Signature and title of certifier (a MM)	1		29c. License nu O.C.M.E			9d. Date signed (M January 1, 2010	
El		30. Name and address of person who completed cause of de Zabiullah Ali, M.D. Assistant Medical Ex	-	•	Street, Baltimo	ore, MD 2120)1		
Sta	ite	31. Date filed (Month, Day Year) 32. Registrar	s Signature	Mad					

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 2 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Month 14:0 Mary Alice White Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death Union Memorial Baltimore Baltimore Funeral Social Security Number 7. Age (In yrs. last birthday If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign Month, Day Year) 1 M 2 XF Months Days Hours Min NC (Director 218-48-7365 64 Usual Residence of Decedent ral", or Items 23a or 28a-f shov Examiner must be notified at 10a. State 10b. County 10c. City, Town or Location Director 10d. Inside City Limits Wicomico Fruitland MD 1 X Yes 2 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 304 Herbal Ct 21826 12. Was Decedent Ever in U.S. Armed Forces?

1 Yes 2 No If Yes, Give 11. Marital Status Was Decedent of Hispanic Origin? (Specify Yes or No-14. Race - American Indian If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Black, White, etc. 1 Never Married 2 Married þ Maryland 21215-0036 hours after 1 Yes 2X No Specify: "natural", 3 XWidowed 4 Divorced Completed Black Year or Dates the Medical 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Il Hygiene. Elementary/Seconday (0-12) College (1-4 or 5+) should be filed with and Mental Hygier Is marked other t Production Laborer Campbell Soup Co other traumatic event, Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Franklin Fields Gertrude Jones permit. Page 1 and 2 should t Department of Health and Me Important: If item 27 Is mark 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Barbara Howell/Daughter Box 3805, Salisbury, MD 21802 Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) West Post Office Rd 1 X Burial 2 Cremation 3 Removal from State injury or st. Mary's Cem 12-19-2009 Princess Anne, MD 4 Donatton 5 Other (Specify) Signature of Funeral Service Licensee 22. Name and Address of Facility 917 W. Isabella St Bennie Smith Salisbury. MD 21801 Funeral Home 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Immediate Cause (Final Onset and Death Physician/ disease or condition oronar Medical resulting in death) Due to (or as a consequence Examiner Sequentially list conditions, if any leading to immediate cause. Enter Underlying Cause (Disease or iinjury that initiated events southing in death). Examine Due to (or se a nunsequence of): the burial-transit Due to (or as a consequence of): resulting in death) Last physiciar Physician/Medical that the death certificate be P.O. Box 68760 as IF FEMALE: use 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery Ectopic pregnancy for in the past 12 months? Month Day Pregnant at time of death 5 Other (specify) Year Yes 2 No the detached 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ page 2 should be Division of Vital Records, or Attending Physician; The law requires 2 No 3 Probably 4 Unknown Completed 1 Yes has been 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy berformed? certificate 1 Yes 2 No 25. Was case referred to medical the funeral director, Certificate: To Be 26. Place of Death (Check only one) examiner? 2 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA within 24 hours after death.

To the Funeral Director: After this completed filled in by the funeral directions. 4 Nursing Home 5 Residence 6 Other (Specify) 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at work? 1 ☐ Yes 2 ☐ No 28d. Describe how injury occurred 1 Natural 5 Pending injury Investigation Could not be Accident Suicide 3 ☐ Suiciae 4 ☐ Homicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Hospital Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one) 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) 30. Name and address of person who cor ed cause of death (Item 23a) (Type, Print) Michae

Registrar
DHMH 17 Rev 7/2009

State

31. Date filed (Month, Day, Year)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ 916 Patricia A. Ward Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** KICOMICO BAL13641 If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign Age (In yrs. last birthday) **Funeral** 1 □ M 2 🕱 F Days 10/06/1946 Yrs. Director 63 216-50-7228 <u>Marvland</u> Usual Residence of Decedent 28a-f show 10b. County 10a. State 10c. City, Town or Location 10d. Inside City Limits 72 hours after death with the Maryland iral", or items 23a or 28a-f sho Examiner must be notified at Direct 1 X Yes 2 No Maryland Wicomico Salisbury 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code Funeral USA 21804 4811 Goose Creek Drive 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. Completed by 1 Never Married 2 Married 1 ☐ Yes 2 🛣 No If Yes, Give Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify: Specify: White and Mental Hygiene. 3 Widowed 4 Divorced Year or Dates permit. Page 1 and 2 should be filed within 72 hours Department of Health and Mental Hygiene. Important: If item 27 is marked other than "naturany injury or other traumatic event, the Medical. 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business Industry College (1-4 or 5+) Elementary/Seconday (0-12) Domestic Homemaker Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ၉ Jean Marinelli Pasquale W. Rocco 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 4811 Goose Creek Dr., Salisbury, Maryland 21804 Terry Ward/husband 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 X Burial 2 Cremation 3 Removal from State 12/18/2009 Salisbury, Maryland Parsons Cemetery 4 Donation 5 Other (Specify) 22. Name and Address of Facility Holloway Funeral Home P.A. 21. Signature of Fuperal Service Licenses Maryland 21804 Snow Hill Rd., Salisbury, 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ Pancreation disease or condition Medical resulting in death) Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Due to (or as a consequence of): Exami that the death certificate be executed Cause (Disease or iinjury that initiated events resulting in death) Last sician and burial-tran Due to (or as a consequence of): attending physician I for use as the buria Physician/Medical Box 68760 yes, outcome of pregnancy Live Birth 2 Fetal death Pregnant at time of IF FEMALE: 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Day Month Year 5 Other (specify) g 🗌 Unknown P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ≥ 1 ☐ Yes 2 No 3 ☐ Probably 4 ☐ Unknown Records, Completed page 2 should 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has performed 1 Yes 2 No certificate nin 24 hours after death. the Funeral Director: After this certiflo npleted filled in by the funeral director, To the Hospital or Attending Physician: To Be 25. Was case referred to medical 26. Place of Death (Check only one) Division of Vital Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 XiYes 2 No 1 Inpatient 2 X ER/Outpatient 3 DOA 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at work? Certificate: Natural 5 Pending 1 Yes 2 No Accident Suicide Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 - Homicide determined within 24 hours a To the Funeral I completed filled Medical 1 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 29a. Certifier (Check 3 🗌 🐧 Rutifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature 29d. Date signed (Month, Day, Year) 16/09 1450497 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Salisbury, Maryland 21801 100 E. Carroll St.

Registrar

DHMH 17 Rev 7/2009

State

Chris Snyder
31. Date filed (Month, Day, Year)

DEC

32 Registrar's Signatur

Please Type or Print in Black Indelible Ink, Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Dec. 17, 2009 Chester Wycoski 2:39рм Albert Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Bethesda Montgomery Suburban Hospital Social Security Number If Under 1 Year If Under 24 Hrs. 7. Age (In vrs. last birthday) 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** Months Days Hours Min Country (Month Day Year) 921 Director 88 177-12-3703 Usual Residence of Decedent 10b. County Page 1 and 2 should be filed within 72 hours after death with the Maryland ment of Health and Mental Hygiene.
ant: If item 27 is marked other than "natural", or items 23a or 28a-f shoury or other traumatic event, the Medical Examiner must be notified at 10a. State 10c. City, Town or Location 10d. Inside City Limits Director MD Montgomery Rockville 1 ☐ Yes 2 🔀 No 10e, Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 20853 USA 13542 Vandalia Drive Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 11. Marital Status 14. Race - American Indian Armed Forces? Black, White, etc ģ 1 Never Married 2 Married 1 Yes Maryland 21215-0036 1 ☐ Yes 2 🙀 No Specify: Specify: White Completed 3 Widowed 4 Divorced Year or Dates 16a. Decedent's Usual Occupation
(Give kind of work done during most of working
life, DO NOT use retired)
Steamfitter Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) Dept. of Defense Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ၉ Benjamin Wycoski Mary Wywoda 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Ellen Wycoski/Daughter 12813 Bushey Drive Silver Spring, Md 20906 Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Department of H Important: If ite any injury or ott Date cemetery, crematory or other place 1 ☐ Burial 2 😾 Cremation 3 ☐ 月emoval from State 12/21/2009 Beltsville,Md Chesapeake Crem. 4 Donation 5 🗆 Other (Spe . Signature PHILIP de RINALDI FUNERAL SERVICE, P.A. 9241 Columbia Blvd.Silver Spring, Md20910 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician disease or condition resulting in death) Pneumonia Medical Due to (or as a consequence of): Examiner Sequentially list conditions. Examine if any, leading to immediate cause. Enter Underlying Due to (or as a consequence of) the attending physician and hed for use as the burial-transil Cause (Disease or ii that initiated events Due to (or as a consequence of) resulting in death) Last Physician/Medical IF FEMALE 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Day Pregnant at time of death 5 Other (specify) 9 Unknown g Unknown signed by to detach Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by Records, congestive heart failure 1 ☐ Yes 2 😾 No 3 ☐ Probably 4 ☐ Unknown director, page 2 should been 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☐ No 24a. Was an atrial fibrillation Jas autopsy performe certificate I Yes 2 🔀 No Be 25. Was case referred to medical 26. Place of Death (Check only one) examiner?

1 Yes 2 No Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 은 1 X Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA this vithin 24 hours after death.

To the Funeral Director: After this completed filled in by the funeral of 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at Certificate: 28d. Describe how injury occurred Hospital or Attending 5 Pending work? 1 Natural Division 2 🗆 No Accident Suicide Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State To the Hospital within 24 hours a To the Funeral C Medical 29a. Certifier 🕍 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check

8 Albert Wy Coski

> State Registrar

31. Date filed (Month, Day, Year) **DEC 23** 2009

3

osence e and address of person who con

29b. Signature and title of certifier

600 Old Georgetown Rd Bethesda, Md 20814 Rosemary Indunze M.D. Registrar's Sig

d cause of death (Ite

Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29c. License numbe

D0065720

29d. Date signed (Month, Day, Year)

Dec.17,2009

			T- State of Maryland / Dep Registrar State of Maryland / Dep	artment of Health and I ertificate of Death		ne No.2009 428	79
	Physici	an	Decedent's Name (First, Middle, Last)		2. Date of Death December	3. Time of Dea	
	/Medic	al	4a. Facility Name (If not institution, give street and number)	4b. City, Town, or Location of Death	1	4c. County of Death	• IVI
ment of	Funeval		Laurel Regional Hospital 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday	Laurel If Under 1 Year If Under 24 Hrs.		Prince George's 9. Birthplace (State or Fo	oreign
L	Funeral Director		139-56-5051 1\(\overline{\text{M}} \) M 2 \(\text{F} \) 52 Yrs. \(\overline{\text{V}} \) Usual Residence of Decedent	Months Days Hours Min.	8. Date of Birth (Month Day, Aug. 18, 1	957 New Jersey	
	Maryland a-f show	ctor	10a. State 10b. County 10c. City, Town or L 10c. City, Town or L 10c. City Town or L 1	ocation		10d. Inside City Li 1	
	th with the 23a or 28a	Funeral Director	10e. Street and Number 6983 Mayfair Terrace	10f. Zip Code 20707		Citizen of What Country? nited States	
036	be filed within 72 hours after death with the Maryland tal Hygiene. d other than "natural", or items 23a or 28a-f show event, the Medical Energine Institute at event, the Medical Energine Institute Institute Institute Ins	by	11. Marital Status 1 Never Married 2 Married 3 Widowed 4 Divorced 12. Was Decedent Ever in U.S. Armed Forces? 1 Yes 2 No If Yes, Give Year or Dates:	Was Decedent of Hispanic Origin? (S If Yes, specify Cuban, Mexican, Puerto 1 □Yes 2∑No Specify:	pecify Yes or No- o Rican, etc.)	14. Race - American Indian, Black, White, etc. Specify: White	
Maryland 21215-0036	within 72 ho lene. than "natur ne Medical	Completed	(Specify only highest grade completed) (Give life.	edent's Usual Occupation e kind of work done during most of wor DO NOT use retired) ECTOT	king	b. Kind of Business/Industry	
and 2		æ	17. Father's Name (First, Middle, Last) Raymond Williams		ne (First, Middle, Mai	den Surname)	
aryl	permit. Pages 1 and 2 should be Department of Health and Mental Important: If item 27 is marked of any injury or other traumatic ev ance.	2	19a. Informant's Name/Relationship (Type. Print) 19b. Mail	ing Address (Street and Number or Ru	ıral Route Number, C		
ē, ≥	Health tem 27 other tr			8 Heather Knolls I osition (Name of phatory or other place)		1ton, VA 20158 c. Location - City or Town, State	
Baltimore,	trant of tant: If it it it or o		4 Donation 5 Other (Specify)	Cemetery 12/27/		lermo, New Jersey	
Ba	permit. Departr Imports any inji		21. Signature of Funeral Service Licensee Discontinuous Company Di	onald V. Borgwardt 400 Powder Mill Ro	t Funeral oad Beltsv	Home, PA ille, Maryland 20	705
Jan.	Physician		23a. Part 1. Enter the disease, or complications that caused the death. Do not er shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition a. Ventricular Fibrical Actions a.	nter the mode of dying, such as cardiac			en
	/Medical Examiner		Myocardial Infare	ction			
5	uted d ansit	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death). Leaf	sis			
38760,	icate be executed physician and s the burial-transit		resulting in death) Last Due to (or as a consequence of): Hypertensive Card				
O. Box (death certif e attending ed for use as	Physician/Medical		□ Ectopic pregnancy □ Other (specify)		23d. Date of delivery Month Day Yea	r
rds, P.	requires that the been signed by th hould be detache	by	Part II. Other significant conditions contributing to death but not resulting in the	inderlying cause given in Part I.		cco use contribute to the cause of deat 2 ☐ No 3 ☐ Probably 4 ☒ Unki	
Division of Vital Records,	The lar	Completed			24a. Was an autopsy performe 1 □ Yes 2∆	24b. Were autopsy findings ava prior to completion of caus death? □No 1 □ Yes 2 ☒ No	ilable e of
1 VIII	ysician; iis certific director,	To Be	25. Was case referred to medical examiner? 1 ☐ Yes 2 X No Hospital: 1 ☐ Inpatient 2 X ER/Outpatie		ath (Check only one) Iome 5 ☐ Residence	e 6 ⊡Other <i>(Specify)</i>	
o uo	ding Ph h. After th funeral	tion:	27. Manner of Death 1 № Natural 5 Pending 2 □ Accident investigation 28a. Date of Injury (Month, Day, Year) (Month, Day, Year) 28b. Time (Month, Day, Year)	of 28c. Injury at Work? M 1 □ Yes 2 □ No	28d. Describe how		
DIVISI	To the Hospital or Attending Physician: within 24 hours after death. To the Funeral Director: After this certifical completely filled in by the funeral director,	Certification:	3 ☐ Suicide 4 ☐ Homicide 6 ☐ Could not be determined 28e. Place of Injury - At home, farm, si building, etc. (Specify)		28f. Location (Stree City or Town, S	et and Number or Rural Route Number State)	;
	the Hospitain 24 hours the Funeral pletely fille	Medical (29a. Certiffier (Check only one) 1 Certifying Physician: To the best of my knowledge, dea 2 Medical Examiner: On the basis of examination and/or and manner stated.	nvestigation, in my opinion, death occu	urred at the time, date	and place, and due to the cause(s)	
	Verith Con To To To To To To To To To To To To To	Σ	29b. Signature and title of certifier	29c. License number	29d	Date signed (Month, Day, Year)	
,	LU		30. Name and address of person who completed cause of death (Item 23a) (Type Wang Kwong Koon, M.D. 7300 Van Dusen	, Print)			
ı	Sta Registr		Of Date filed (March Day Vers)	A.S.		\	

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month Physician/ 1810 Douglas Wearn Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner HICOMICO Salisbui Centu eninsula If Under 1 Year If Under 24 Hrs. Social Security Number . Age (In yrs. last birthday) 8. Date of Birth 9. Birthplace (State or Foreign Funeral 1 X M 2 □ F (Month, Day, Year) Months Days Hours Min. Country) Michigan Director 386-50-3639 Usual Residence of Decedent or 28a-f show 10a, State 10b. County 10c. City, Town or Location 10d. Inside City Limits ?7 is marked other than "natural", or items 23a or 28a-f sho traumatic event, the Medical Examiner must be notified at Director DE Sussex Delmar 1 X Yes 2 □ No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 36075 Bi-State Blvd. 19940 USA 72 hours after death 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian Armed Forces? Black, White, etc. δ 1 Never Married 2 Married Maryland 21215-0036 1 ☐ Yes 2 X No Specify: Specify: White Completed 3 Widowed 4 X Divorced Year or Dates. Army 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) permit. Page 1 and 2 should be filed within 72 Department of Health and Mental Hygiene. Important: If item 27 is marked other than ' Elementary/Seconday (0-12) College (1-4 or 5+) q Security Guard Security Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ၉ Norman Wearn Marie Miller 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Lisa Messick (Daughter) 36075 Bi-State Blvd. Delmar, De. 19940 injury or other Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of Date 20c. Location - City or Town, State 1 ☐XBurial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) cemetery, crematory or other place) Bethel Cemetery 12-27-2009 Bethel, Delaware 21. Signature of Funeral Service Licensee 22. Name and Address of Facility 700 West St. Hannigan, Short, Disharoon F.H. Laurel, De. 19956 - DAMMI 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or hearthailure. List only one cause on each line. Approximate Interval Between Immediate Cause (Final Physician/ day disease or condition Medical resulting in death) Di to (or as a consequence of) **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examine burial-transi Cause (Disease or iinjury that initiated events resulting in death) Last attending physician Physician/Medical Box 68760 as the l IF FEMALE: nse yes, outcome of pregnancy Live Birth 2 Left death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ for 1 in the past 12 months? 1 ☐ Yes 2 ☐ No Month Pregnant at time of death signed by the a 9 Unknown 9 Unknown P.O. Part II. Other significant coeditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by Division of Vital Records, 1 Yes 2 No 3 Probably 4 Unknown page 2 should 24b. Were autopsy findings available prior to completion of cause of death? 1 ☐ Yes 2 ☐ No 24a. Was an autopsy performe certificate ! Yes 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 No မ Inpatient 2 ER/Outpatient 3 DOA To the Hospital or Attending Phys within 24 hours after death. To the Funeral Director: After this or completed filled in by the funeral director. After this Certificate: 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at 28d. Describe how injury occurred 5 Pending 1X Natural 1 Yes 2 No Accident Suicide Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Medical 29a. Certifier X Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Continued in Nursa Praction or To the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check 29b. Signature and title or e 29c. License number 29d. Date signed (Month, Day, Year)

Registrar
DHMH 17 Rev 7/2009

State

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

32. Registrar's Signature

Brett Hofmann MD

31. Date filed (Month, Day, Year

D59931

100 E. Carroll Street Salisbury, Maryland 21801

09-10189 George K. Wint	ers	Please Type or State of	Maryland / De		Health ar		Hygiene		2009	4288
Physici	an/	Registrar 1. Decedent's Name (First, Middle,Last)			Death		2. Date of De	ath		3. Time of Death
Medical Exam		GEORGE KENNETI					Month December			1600 hrs
		4a. Facility Name (if not institution, give s 9520Jazz Place			tb. City, Town, o LaPlata			Ch	County of Deatl	
Funeral Director		5. Social Security Number 6. Sex 213-84-8567	7. Age (In y	yrs. last birthday) 47 Yrs	If Under 1 Year Months Day		Min. FEB.		Co	thplace (State or Foreig untry) D •
Aaryland 28a-f show any 1 at once.		Usual Residence of Decedent 10a. State 10b. County MD • CHARLES		City, Town or Locati	on PLATA					10d. Inside City Limits 1 X Yes 2 No
arylan 8a-f si	Director	10e. Street and Number			10f. Zip Code		1	10g. Citize	n of What Cou	ntry?
the M a or 2 tified	Dire	9820 JAZZ PLACE	E		206	46		U.S.	Α.	
more, MD 21215-0036 Pages I and 2 should be filed within 72 hours after death with the Maryland tent of Health and Mental Hygiene. nnt: If item 27 is marked other than "natural", or items 23a or 28a-f shorr other traumatic event, the Medical Examiner must be notified at once.	Funeral	11. Marital Status 1 X Never Married 2 Married	2. Was Decedent Ever Armed Forces? Yes 2 X	If Yo	s Decedent of Hi es, specify Cuba		Specify Yes or Nerto Rican, etc.)	0- 14	Race - Amer White, etc.	can Indian, Black,
s after ral",	by	3 Widowed 4 Divorced If or 15. Decedent's Education (Specify only	Dates:		Yes 2X No				pecify:BLA	
2 hour	eted	Elementary/Secondary (0-12)	College (1-4 or 5+)	during mo	ost of working life			TOD. KIN	d of Business/	ndustry
21215-0036 uold be filed within 72 hours after Mental Hygiene. marked other than "natural", c event, the Medical Examiner	Completed	1 2 17. Father's Name (First, Middle, Last)		LA	NDSCAP		me (First, Middle,		F EMP	LOYED
21215 uld be file Mental H. marked o	Be (JOSEPH MATTHE	CWS WINTER	RS,SR.		ELLA	LEE WAT	TS	,	
s, MD 21 and 2 should tealth and Me tem 27 is ma traumatic ex	To	19a. Informant's Name/Relationship (Type JOSEPH WINTERS, S	,		Address (Stree		or Rural Route Nu LA PLA			
Baltimore, M permit. Pages I and 2 Department of Health Important: If item 2 injury or other traum		20a. Method of Disposition 1 Surial 2 Cremation 3 4 Donation 5 Other Specify:	Removal from State	0b. Place of Disposi crematory or oth SACRED H	er place)	· 1	Date - 5 - 2010		eation - City or PLATA	
alti rmit. spartm nporta jury o		21. Signature of Funeral Service Ligensee	M00479	22. N	ame and Address	s of Facility	I CEDUI	CE D	7)	
Physician		23a. Part Nenter the disease, or complica failure. List only one cause on each		eath. Do not enter th	PLATA e mode of dying,	MD. 2 such as cardia	L SERVI 0646 c or respiratory ar	rest, shock	, or heart	Approximate Interval Between Onset and
/Me dical Examiner		Immediate Cause (Final disease or condition resulting in death)	equired imm	unodefici ce of): With h	ency syn	ndrome	(AIDS) a	ssoci	ated	Death
	iner	cause. Enter Underlying Cause	to (or as a consequent	ce of j.						
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e exec	Jica	X UNPENDED	MENDED 23a,27	28a-f ne	rmE a80	99 1/25	/10 TT			
Division of Vital Records, P.O. Box 68760, within 24 hours after death. To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial - transit		IF FEMALE: 23b. Was decedent pregnant in the past 12 months?	3c. If yes, outcome of p	2 Fet	al death 3				Date of delivery	ay Year
Box death he atte d for u	ysic	1 Yes 2 No 9 Unknown		5 Oth	er (Specify)					
rds, P.O. B requires that the de been signed by the hould be detached i		Part II. Other significant conditions co	ntributing to death but n	ot resulting in the ur	nderlying cause o	given in Part I.				the cause of death? ably 4 Unknown
cords, F e law requires e has been sign e 2 should be	Completed by			·				osy ormed?	prior to c death?	copsy findings available completion of cause of
Vital Recolysician: The law		25. Was case referred to medical			26.Place	of Death (Chec		2No	1 🗸 Ye	s 2 No
Vita Nysicia this cer	Ö		ital: 1 Inpatient 2	ER/Outpatient				Residence	e 6 🗸 Other	Scene
Division of Vital Records, P.O. Isl or Attending Physician: The law requires that it is after death. al Director: After this certificate has been signed by led in by the funeral director, page 2 should be detacted.	ation: T	27. Manner of Death 1 Natural 5 Pending 2 X Accident Investigation	28a. Date of Injury (Month, Day, Year) Fd 12/29/09	28b. Time of In		ry at Work? Yes 2 X No	28d Describe subject ambient		oscumed to sed to	
Division To the Hospital or Attend within 24 hours after death To the Funeral Director:	Sertification:	3 Suicide 6 Could not be determined	28e. Place of Injury - A	At home, farm, street		uilding, etc.		Street and	Number or Rui	al Route Number, City
To the Hosp within 24 ho To the Fune completely f	Medical C	one) 2 Medical Examiner: On	To the best of my know	rledge, death occurr						
F 3 F 8	Me	29b. Signature and title of certifier	1 A		29c. Licens O.C.I				e signed (Mon	
	H	in Miller						1		

State Registrar

DHMH 17 Rev 1/2001 OCME 2006

31. Date filed (Month, Day, Year)

JAN 0 8 2010

Zabiullah Ali, M.D.

32. Registrar's Signature

Assistant Medical Examiner

OCME

111 Penn Street, Baltimore, MD 21201

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 42882 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death 6:40 рм 09 2009 December Josephine Avgoustatou 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death Silver Spring Montgomery Arcola Nursing Home 5. Social Security Number 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) 1 □ M 2 🗓 F 85 Egypt 219-88-2881 Usual Residence of Decedent 10a. State 10c. City, Town or Location 10d. Inside City Limits 1 ☐ Yes 2 No Olney Maryland Montgomery 10g, Citizen of What Country? 10e. Street and Number 10f Zip Code 3032 Ohara Place 20832 U.S.A 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates; Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11 Marital Status Black, White, etc. 1 Never Married 2 Married 1 ☐Yes 2 🗓 No Specify. Specify. White 3 Widowed 4 Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Child Care Provider Child Care 12 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Guirgis Unknown Almaza 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Emad F. Abdelseid - Spouse 3032 Ohura Place, Olney, Maryland 20832 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 ☐ Burial 2 X Cremation 3 ☐ Removal from State 4 □ Donation 5 □ Other (Specify) Lincoln Crematory 12/17/2009 Brentwood, Maryland 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Simple Tribute & Cremation Ctr. 1040 Rockville Pike, Ruckville, MD 20852 Approximate Interval Between Onset and Death 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Senility Due to (or as a consequence of): Sequentially list conditions, if any, leading to Immediate cause. Enter Underlying cause, Usease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Due to (or as a consequence of). IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy

Physician /Medical Examiner

Physician

/Medical

Examiner

Director

Funeral

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Completed

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Funeral

Director

permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hyglene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Exerciting to ust be natified at

Baltimore, Maryland 21215-0036

law requires that the death certificate be executed

Hospital or Attending Physician: The

To the within 2

Division of Vital Records, P.O. Box 68760,

physician and s the burial-trans attending p for use as t page 2 s n 24 hours after death.

■ Funeral Director: Apletely filled in by the fi

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Medical

1 ☐ Yes 2 ☑ No 9 ☐ Unknown	4 ☐ Pregnant at time of death 5 ☐ Othe 9 ☐ Unknown	er (specify)		Month L	Day fear
Part II. Other significant conditions	s contributing to death but not resulting in the underlyl	ing cause given in Part I.	23e. Did tobacco u	se contribute to the	cause of death?
<u>Hypertension</u>			1 ☐ Yes 2 🛭	[] No 3 □ Proba	bly 4 ☐ Unknown
<u>Hypothyroidism</u> Anemia	1		24a. Was an autopsy performed?	prior to com death?	sy findings available pletion of cause of
25. Was case referred to medical		26. Place of Death (Check only one)		
examiner? 1 □ Yes 2 汉 No	Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐	☐ DOA Other: 4 🔀 Nursing Home	e 5 ☐ Residence 6	☐Other (Specify)	
27. Manner of Death 1 ☑ Natural 5 ☐ Pending 2 ☐ Accident investigat	28a. Date of Injury (Month, Day, Year) 28b. Time of Injury M	Work?	d. Describe how injury	occurred	
3 Suicide 6 Could not 4 Homicide determine		ctory, office 28	f. Location (Street and City or Town, State)		Route Number,
	Physician: To the best of my knowledge, death occu caminer: On the basis of examination and/or investigation and manner stated.				
29b. Signature and title of certifier	//	29c. License number	29d. Dat	e signed (Month, D	ay, Year)

D56691

December 14, 2009

State Registrar

Ghousia Sultana. 31. Date filed (Month, Day, Year) DEC 22

30. Name and add ess of person who completed cause of death (Item 233, Tyrre, Print)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ December 7:10 am 2889 Edward Bryan Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner 4006 Thornapple Street Chevy Chase Montgomery . Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign Funeral 1 🗓 M 2 🗆 F Months Days Hours 1 6 930 7 7 924 Wisconsin 387-20-6641 **Director** 85 Usual Residence of Decedent ral", or items 23a or 28a-f show Examiner must be notified at 10c. City, Town or Location 10a. State 10d. Inside City Limits within 72 hours after death with the Maryland Director 1 X Yes 2 □ No Chevy Chase Maryland Montgomeru 10f. Zip Code 10e. Street and Number 10g. Citizen of What Country? Funeral 4006 Thornapple Street 20815 U.S.A. 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Armed Forces? Black, White, etc. "natural", or i þ 1 Never Married 2 X Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify. If Yes, Give Year or Dates Specify: Completed 3 Divorced 4 Divorced WWII White the Medical 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life, DO NOT use retired) National Science and Mental Hygiene. College (1-4 or 5+) **5**+ Elementary/Seconday (0-12) Civil Environmental Engineer Foundation Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) be 1 Theresa Piotrowski Stanley Brykczynski 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) . Page 1 and 2 sh ment of Health a tant: If item 27 is Chevy Chase, Maryland 20815 Dolores Bryan - Spouse 4006 Thornapple St.. permit. Page 1 and 2 Department of Healt Important: If item 2 any injury or other 1 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 Burial 2 X Cremation 3 Removal from State Lincoln Crematory: 12/21/2009 Brentwood, Maryland 4 Donation 5 Other (Specify) 22. Name and Address of Facility Simple Tribute & Cremition Ctr. Signature of Funeral Service Licensee 1040 Rockville Pike, Rockville, Maryland 20852 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or fleart failly red. List only one cause on each line. Approximate Interval Between Onset and Death Pnysician/ Idiopathic Pulmonary Fibrosis disease or condition resulting in death) Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examine Due to (or as a consequence of): The law requires that the death certificate be executed attending physician and for use as the burial-transi Cause (Disease or iinjury that initiated events resulting in death) Last Due to (or as a consequence of) Physician/Medical Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? 5 Other (specify) Month Day Year Pregnant at time of death Yes 2 No signed by the a d be detached f 9 Unknown Division of Vital Records, P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 ☐ Yes 2 🛣 No 3 ☐ Probably 4 ☐ Unknown cate has been sig page 2 should b Completed 24b. Were autopsy findings available prior to completion of cause of 24a. Was an autopsy performed? death? After this certificate I funeral director, page 2 🗆 No Yes To the Hospital or Attending Physician: I within 24 hours lifer det th.

To the Funeral Lirector After this certifics completed filled in by the funeral director, t Be 25. Was case referred to medica 26. Place of Death (Check only one) Other: 4 Nursing Home 5 X Residence 6 Other (Specify) 1 🗌 Yes 2 X No မြ 1 Inpatient 2 ER/Outpatient 3 DOA 27 Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of Certificate; 28c. Injury at 28d. Describe how injury occurred 1 X Natural 5 Pending 1 🗌 Yes 2 🗌 No 2 Accident
3 Suicide
4 Homicide Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) Location (Street and Number or Rural Route Number, City or Town, State) Medical 1 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 29a. Certifier (Check Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29b. Signature and tipe of ce 29d. Date signed (Month, Day, Year) 7+1 MDD33554 December 16, 2009 ause of death (Item 23a) (Type, Print) 30. Name and add ess of person eted c

Registrar
DHMH 17 Rev 7/2009

State

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DEC 22

31. Date filed (Month, Day, Year)

John

5410

2. Registrar's Signature

Connecticut Avenue #117, NW Washington, DC 20015

			For State Registrar	State of Maryla		oartment of ertificate of		Mental Hy	giene Reg. No	109	42881
	Physici		Decedent's Name (First, Middle, Lass WILLIAM EDWARD	BROSCHART	Sr.			2. Date of De Month Decemb	Day	2009	3. Time of Death 12:05 A ^M
Service of the servic	/Medic Examin		4a. Facility Name (If not institution, give Sunrise Assisted	Living of F		k Frede		h	4c. Cou Fre	nty of Death	K
	Funeral Director		5. Social Security Number 6. Social Security Number 579–12–3048 Usual Residence of Decedent	x 7. Age (In y x 1	rs. last birthda Yrs.	y) If Under 1 Yea Months Day				Cour	place <i>(State or Foreig</i> ntry) yland
	the Maryland r 28a-f show	Director	10a. State 10b. County Maryland Frederi 10e. Street and Number		City, Town or	Location lerick 10f. Zip Code			10g. Citizen		l 0d. Inside City Limits 1 □Yes 2 ☒ No ntry?
036	s 1 and 2 should be filed within 72 hours after death with the Maryland of Health and Mental Hygiene. Item 27 is marked other than "natural", or items 23a or 28a-f show other traumatic event, the "Marial Experience or a	by Funeral	990 Waterford Driv 11. Marital Status 1 Never Married 2 Married 3 Widowed 4 Divorced	7e 12. Was Decedent Ever in Armed Forces? 1 ☐ Wes 2 ☐ No If Yes, Give Year or Dates:	n U.S. 13		702 i Hispanic Origin? (S iban, Mexican, Puer o <i>Sp</i> ec <i>ify:</i>	Specify Yes or No to Rican, etc.)		d Stat Race - Americ Black, White, cify: Wh	can Indian,
21215-0036	12 should be filed within 72 ho h and Mental Hygiene. 7 is marked other than "natur traumatic event, the Medical	Completed	15. Decedent's Ed (Specify only highest grades) Elementary/Secondary (0-12)	ucation de completed) College (1-4or 5+)	(Gir	cedent's Usual Occ re kind of work don DO NOT use reti	e during most of wo red)	rking		Business/In	
pu	be filed tal Hy d othe event,	Be	17. Father's Name (First, Middle, Last)					me (First, Middle	, Maiden Surr		
ryla	d Men d Men narke natic	2	Frank J. Broschart					Hender		01.1. 7	- 0- 1-)
e, Ma	1 and 2 st Health an em 27 is r ither traur		19a. Informant's Name/Relationship (7 Sarah K. Younger 20a. Method of Disposition	(Daughter)	1213		noll Circ		t Fall		22066
Baltimore, Maryland	t. Page rtment c rtant: If rjury or		1 ☑ Burial 2 ☐ Cremation 3 ☐ 4 ☐ Donation 5 ☐ Other (Specify	Removal from State)	t. Mary	ematory or other p 7's Rockv	ille 200	• 23 09	Rocky	ille,	
Bal	permi Depai Impo any Ir		21. Signature of Funeral Service Licen	Kay		10 East	ress of Facility D Deer Park	Dr. Gai	thersb		Approximate
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O. Box 6	the death certific y the attending p ched for use as	Physician/Me	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	23c. If yes, outcome of pre 1 ☐ Live birth 2 ☐ F 4 ☐ Pregnant at time 9 ☐ Unknown	etal death	3 ☐ Ectopic pregna 5 ☐ Other (specify)				Date of d eliv Month	ery Day Year
σ.	w requires that the desident speeds speed by the should be detached	ρ	Part II. Other significant conditions of	ontributing to death but not	resulting in the	underlying cause (given in Part I.	23e. Di d t			he cause of death? bably 4 🗌 Unknown
Division of Vital Records,	: The law re cate has be , page 2 sho	Completed	Cosmany	artery	Dise	ase		24a. Was auto perfo 1 □ Yes			opsy findings available opposed in the properties of a second sec
Vita	sician: The certificate rector, pag	Be	25. Was case referred to medical examiner? 1 ☐ Yes 2 ☑ No	Hospital:			Alle a v.	ath (Check only o			Assisted
on of	Attending Physician: sr death. ector: After this certifica by the funeral director, p	tion: To	1 Yes 2 No 27. Manner of Death 1 Natural 5 Pending 2 Accident investigation	1 ☐ Inpatient 2 28a. Date of Injury (Month, Day, Year	28b. Time	of 28c. In	4 LI Nursing i	28d. Describe			_{fy)} Living
Divisi	al or Atter s after dea Il Director ed in by the	Certification:	3 Suicide 6 Could not be determined	28e. Place of Injury - A building, etc. (Sp.	At home, farm, secify)	street, factory, office	е	28f. Location (City or To		mber or Run	al Route Number,
	To the Hospital or Attendi within 24 hours after death. To the Funeral Director: A completely filled in by the fi	edical C		/sician: To the best of my iner; On the basis of exan and manner stated.							
	To the vithin 2 to the complex	Me	29b. Signature and title of certifier				1643		29d. Date sig	21 0 C	Day, Year)
			30. Name and address of person who o			e, Print)	1	ick, MD	21702		

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State Registrar 31. Date filed (Month, Day, Year)

DEC 2 2 2009

32 Registrar's Signature

Baltimore, Maryland 21215-0036 Division of Vital Records, P.O. Box 68760

		Fieds	Chata of Manual					_	ž•
		For State	State of Maryla	•	tificate of L			0000	42885
		Registrar 1. Decedent's Name (First, Middle, L	act)	Cer	uncate of L	Jean .	2. Date of Dea	Reg. No 2 0 0	
Physicia	n/			1-1			Month	Day Year	3. Time of Death
Medic Examin		Harold W 4a. Facility Name (if not institution, g		klew	4h City Town or	r Location of Death		4c. County of De	110
	G1		rd Regional Hed	lical Contro	- 1 I	nortan	d	Allea	any
Funeral				last birthday)	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birtl	h 9. B	hirthplace (State or Foreign
Director		213-44-1604	1 AJ M 2 LJ F	64 Yrs.	WIOTILIS Days	Ylodis Iviiii.	June 2	28,1945 M	laryland
how at	ŗ	Usual Residence of Decedent 10a. State 10b. County	10c. C	City, Town or Loc	ation			· · ·	10d. Inside City Limits
anylar ka-fs	ectc			0 = 1=1 =					1X□ Yes 2 □ No
or 28 e not	Ω̈́	MD G 10e. Street and Number	arrett	0akla	10f. Zip Code			10g. Citizen of What C	Country?
filed within 72 hours after death with the Maryland al Hygiene. 1 other than "natural", or items 23a or 28a-f sho went, the Medical Examiner must be notified at	Funeral Director	600 Glade Squ	are Apt #29		215	50		U.S.A.	
item:		11. Marital Status	12. Was Decedent Ever in U Armed Forces?	J.S. 13. V		ispanic Origin? (Sp an, Mexican, Puerto	ecify Yes or No-	14. Race - Am Black, Wh	nerican Indian,
after o	Completed by	1 X Never Married 2 Marrie	d 1 ☐ Yes 2 ☒ No If Yes, Give		☐ Yes 2 🔯 No		, , , , , , , , , , , , , , , , , , , ,	Specify:	
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within giene. er tha	ပိ	Elementary/Seconday (0-12) 1 2	College (1-4 or 5+)	Dis	sabled			None	
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ld be Ment arke	ပ	Howard	Bu	cklew		Cathe	rine	Zim	nmerman
shou and is m		19a. Informant's Name/Relationship	(Type, Print)					; City or Town, State, 2	
and 2		George Zimmer 20a. Method of Disposition				n RD, O		MD 2155	
nt of I nt of I t: If it		1 ☑ Burial 2 ☐ Cremation 3	Removal from State		atory or other plac		Date	20c. Location - City of	
permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.		4 ☐ Donation 5 ☐ Other (Special Special Speci			Cemete:		31/09		Maryland
permi Depar Impor any ir		21. Signature of Puneral Service List	then!	22	230 S	Second	wman Fu St., Oa	ineral Ho akland, M	omes P.A.
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Physician/		Immediate Cause (Final disease or condition	Condine	Arri	Ahmia				Interval Between Onset and Death
Medical Examiner		resulting in death)	Due to (or as a consec		711111111111111111111111111111111111111	- 1			
	<u>.</u>	Sequentially list conditions,	6. Concreti	ue of	eart t	aluve	_		24-72 hs
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eath certificate k attending phys I for use as the i	f edi		- d	~ 4.5					
endin use	an/I	IF FEMALE: 23b. Was decedent pregnant	23c. If yes, outcome of pregr		Ectopic pregnanc	ev		23d. Date of d	lelivery
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sician: The certificate h irector, page		25. Was case referred to medical	1		26 PI	ace of Death (Chec	1 Yes	2 No 1 U Y	es 2 No
Physicia this cert ral direct	To Be	examiner? 1 ☐ Yes 2 X No	Hospital: 1 ☑ Inpatient 2 ☐	☐ ER/Outpatien	Oth	er·		ence 6 Other (Spe	acify)
di ng Ph h. After thi funeral		27, Manner of Death 1 Natural 5 □ Pending	28a. Date of injury (Month, Day, Year)	28b. Time of injury	28c. Injury	y at		ow injury occurred	
eath. or: Af the fu	ifica	2 Accident Investigat 3 Suicide 6 Could no	tion		M 1 □	Yes 2 □ No			
or Att	Certificate:	4 Homicide determine			et, factory, office		28f. Location (S City or Tow	treet and Number or R n, State)	ural Route Number,
• Hospital or Attending Physician: The law requires that the death certificate 24 hours after death. • Funeral Director: After this certificate has been signed by the attending phy eted filled in by the funeral director, page 2 should be detached for use as the		29a. Certifier 1 Certifying P	hysician: To the best of my know	wladga death o	coursed at the time	date and place a	nd due to the car	lea(e) and manner as a	tatod
To the Hosp within 24 hc To the Fund completed 1	Medical	(Check 2 Medical Exa	iminer: On the basis of examination of the best of the best of r	on and/or investi	igation, in my opinio	on, death occurred a	at the time, date a	nd place, and due to the	e cause(s) and manner stated.
To the within 2 To the comple	2	29b. Signature and title of certifier	urse Fractioner, to the best of t	ny knowledge, d	29c. License			29d. Date signed (Mon	
			MD		Don	6140h		12-21-2	2009
		30. Name and address of person wh	o completed cause of death (Ite	m 23a) (Type, P	rint)	^ '	\ \		
	1	600 Home	NICH OLR	Sutc	402 (lenbor	lond 1	MD SI	2007
Stat Registra		31. Date filed (Month, Day Year)	32. Registrar's Sign	ature	A second	,			

DHMH 17 Rev 7/2009

			Please	Type or Print in I					_	ble.		
			For State	State of Marylar	•			Mental Hy	giene			
			Registrar 1. Decedent's Name (First, Middle, Las	*1	Cer	tificate of	Death	2. Date of De	Reg. No. 2	09	42886	
	Physici					L		Month	Day	Year	3. Time of Death	
may.	/Medi Examir		Gerald Ol 4a. Facility Name (If not institution, give		oadwa		or Location of Deat	Dec.	22, 20 4c. County		3:20P [™]	
	Lxuiiii		Dennett Road M	lanor		0aklar	nd		Gar	rett		
	Funeral		Social Security Number 6. Security Number		**	If Under 1 Year Months Days	If Under 24 Hrs.	(Month, Da	rth ay, Year)	9. Birthpla Count		
	Director		217-14-4414 Usual Residence of Decedent		90 Yrs.			May 7	, 1919	Mary	<u>rland</u>	
	yland		10a. State 10b. County	10c. Ci	ty, Town or Loc	ation				10	d. Inside City Limits	
	a-f sl	Director	MD Garre	ett	0akl	and					1 ☐ Yes 2X No	
	72 hours after death with the Maryland natural", or items 23a or 28a-f show digal Evandane.		10e. Street and Number			10f. Zip Code			10g. Citizen of V	Vhat Count	ry?	
	sath v	Funeral	4232 Sand Fla	t Road 12. Was Decedent Ever in U	C 12 VA		550	Posify Vac or N	U.S.	A • e - America	an Indian	
(0	r item	F	11. Marital Status 1 ☐ Never Married 2 ☐ Married	Armed Forces? 1 ☐ Yes 2 ☑ No			Hispanic Origin? (S oan, Mexican, Puert	to Rican, etc.)	Blac	k, White, et		
03	ral", o	d by	3 X Widowed 4 □ Divorced	If Yes, Give The Year or Dates:	1	□Yes 2XNo	Specify:		Specify	Specify: White		
15-0	72 hc "natu	letec	15. Decedent's Edu (Specify only highest grad	ucation de completed)	i (Give k	ent's Usual Occu and of work done	during most of wor	king	16b. Kind of Bu	ısiness/Indu	ustry	
21215-0036	filed within Hygiene. Ither than "	Completed	Elementary/Secondary (0-12)	College (1-4or 5+)	Fore	<i>0 NOT use retire</i> man	ea)		Constr	ucti	on	
	il Hygi other ent, I	Be C	17. Father's Name (First, Middle, Last)		1		18. Mother's Nar	ne (First, Middle	, Maiden Surnam			
/lar	uld be Menta arked atic ev	To B	Beniamin Fran	ıklin Broad	lwater		Rachae	21		Wi	1t	
Maryland	s 1 and 2 should be filed within 72 hours after death with the Marylan if Health and Mental Hyglene. If Health and Mental Hyglene. If I smarked other than "natural", or items 23a or 28a-f show other traumatic event, if a Medical Exaction required to	ľ	19a. Informant's Name/Relationship (7	ype. Print)	19b. Mailing	Address (Stree	t and Number or Ro	ural Route Numb	er, City or Town,	State, Zip (Code)	
ക്	is 1 and 2 of Health item 27 i		Leonaed Broadwa		1317 Place of Dispos		ight Dr.	, Anar	20c. Location -			
nor	ages ant of t: If its y or o		1X Burial 2 ☐ Cremation 3 ☐	Removal from State Ga	rrettery crem	atory or other pla County	ice)			•		
altimore,	permit. Pages 1 Department of I Important: If ite any injury or of		4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licens	Men		Garder Name and Addr	C C	29/09	<u>Oaklan</u>		ryland es P.A.	
m	Depar Impol any ir		Report & Med	terils /	2	03 S. S	Second	S+ 0=	kland	,	21550	
			23a. Part 1. Enter the disease, or comp shock, or heart failure. List only of	lications to the deat ne cause on each ling.	h. Do not ente	r the mode of dy	ing, such as cardia	c or respiratory a	ırrest,		Approximate Interval Between	
	Physician	0	Immediate Cause (Final disease or condition	a Metast	afiz	Prostas	Le Conce	en			Onset and Death	
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0	at the de by the tached	hysi	1 ☐ Yes 2 ☐ No 9 ☐ Unknown	9 🗆 Unknown								
s, P.	ires that signed I be deta	by P	Part II. Other significant conditions co	ntributing to death but not res	-	1	/	23e. Did	tobacco use contr	ribute to the	e cause of death?	
ord	w require been si should b	ted	mal (ell lacino	na, colon las		Done m	etas	1 🗆	Yes 2 No	3 ☐ Proba	ably 4 Unknown	
Vital Records,	has by	Completed	CKN Store 9 4	lo thberco	u 60515	4/01	to pace o use	24a. Was	psy	prior to com	sy findings available pletion of cause of	
			•					perfo 1 □ Yes		death? 1 □ Yes 2	2 X No	
V.	Physiclan: T r this certificat ral director, pa	Be	25. Was case referred to medical examiner?	Hospital:		Oti	26. Place of Dea					
	y Phys er this eral di	n: To	1 ☐ Yes 2 ☑ No 27. Manner of Death	1 ☐ Inpatient 2 ☐ 28a. Date of Injury	28b. Time of	28c. Inju	4 P Nursing F		dence 6 Oth)	
ion	Attending r death. ector: Afte by the fune	atio	1 Matural 5 ☐ Pending 2 ☐ Accident investigation	(Month, Day, Year)	Injury		rk?]Yes 2 □No					
Division	or Atter de Directo in by the	Certification:	3 ☐ Suicide 6 ☐ Could not be 4 ☐ Homicide determined	28e. Place of Injury - At he building, etc. (Specifical Control of the Control of	ome, farm, stre	et, factory, office		28f. Location (City or To	Street and Numb	er or Rural	Route Number,	
	pital c		200 Cortifier	side T. N. s.			Para data and alar					
	To the Hospital or Attending Phwithin 24 hours after death. To the Funeral Director: After th completely filled in by the funeral	Medical	29a. Certifier 1 Certifying Phy (Check only one) 2 Medical Exam	siclan: To the best of my kno iner: On the basis of examina and manner stated.	wiedge, death ation and/or inv	estigation, in my	opinion, death occu	e, and due to the urred at the time,	e cause(s) and ma , date and place, a	unner as sta and due to	ated. the cause(s)	
	To the I within 2 To the I complet	Me	29b. Signature and title of certifier	Ma		29c. Licen	se number		29d. Date signed	1 (Month, E	Pay, Year)	
			1 The flay			Har	104705		12/	23/00	9	
		1	30. Name and address of person who	ompleted cause of death (Iter	n 23a) (Type, P	rint)	anvi-	- 61 1	1	-		
	_ C4-	5	31. Date filed (Mod 1844), 240 CO	32 Aegistrar's Signa	OXUX	da. 22	vupa	NCI M	ID al	DX	/	
	Sta Registr		UEC ZJ ZU	US Lawrence	B. 100			,				

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death **Physician** December 15, 2009 Kenneth Robert Burt /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Frostburg Frostburg Village Nursing Home Allegany If Under 1 Year | If Under 24 Hrs. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** Days Months Hours Min. Maryland Director 220-28-7571 October 18, 1932 Usual Residence of Decedent 10d. Inside City Limits 10b. County permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Important: If Item 27 Is marked other than "natural", or items 23a or 28a-f show any Injury or other traumatic event, the Modical Examinat must be notified at 10a. State 10c. City, Town or Location 1X Yes 2 □ No Director Midland Allegany Maryland 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? **USA** 19802 Church Hill Road, S.W. 21542 Completed by Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 Yes 2 □ No Ir Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11, Marital Status Black, White, etc. 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify. Specify: 3 ☐ Widowed 4 ☐ Divorced White 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Rubber Tire Builder 12 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be James Burt Jane Ritchie မ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Carol Burt - Wife 19802 Church Hill Road, S.W., Midland, Maryland, 21542 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition December Burial 2 Cremation 3 Removal from State Frostburg Memorial Park 18, 2009 Frostburg, Maryland 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Eichhorn-McKenzie Funeral Home P.A. 8 East Main Street Lonaconing, MD 21539 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to include cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Directo for the a consequence off law requires that the death certificate be executed and burial-trar Due to (or as a consequence of) Division of Vital Records, P.O. Box 68760, the attending physician hed for use as the buria Physician/Medical IF FEMALE 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Year Day Pregnant at time of death 5 Other (specify) signed by the a d be detached for 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 2 ficate has been się r, page 2 should b 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a Was an After this certificate 2 No 1 ☐ Yes 1 Yes To the Hospital or Attending Physician: within 24 hours after death.

To the Funeral Director: After this certifica funeral director, Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 | Yes 2 | **∑(1)** | 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To 27. Manner of Death 28a. Date of Injury (Month, Day, Year) Injury at Work? 28d. Describe how injury occurred 1 Aatural 5 Pending 1 ☐ Yes 2 ☐ No investigation 2 Accident filled in by the 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical completely (Check only one) 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 29c. License number

Registrar
DHMH 17 Rev 1/2001

State

925 Bishop Walsh Road, Cumberland, Maryland 2150:

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

09-10069		Places Type or Print in F	Plack Indelible	Ink Engura All Co	nice Are Lor	:hla	
Whitney Nicole		1- For State		of Health and Mental	Hygiene	gible. _{eq. No.} 2009	42888
Physici Medical Exami	an/	Registrar 1. Decedent's Name (First, Middle, Last) Whitney Nicole Brooks			2. Date of Deat Month December	th	3. Time of Death 1145 hrs
		4a. Facility Name (if not institution, give street and number Frederick Memorial Hospital	er)	4b. City, Town, or Location of D Frederick		4c. County of Death Frederick	
Funeral Director		·	Age (In yrs. last birthday)	If Under 1 Year If Under 24 Months Days Hours	Min	th(MM/DD/YYYY) 9. Birt Cou	hplace (State or Foreign intry) aryland
any		Usual Residence of Decedent 10a. State 10b. County	10c. City, Town or Loc	Yrs. cation	Abiti	20, 1507 11	10d. Inside City Limits
rland -f show a	tor	Maryland Frederick	Frederic	ck			1 Yes 2 No
h the Mary 3a or 28a-	I Director	10e. Street and Number 5321 Hines Road		10f. Zip Code 21704		Og. Citizen of What Coun	try?
death with or it or items 2	Funeral			Was Decedent of Hispanic Origin? If Yes, specify Cuban, Mexican, Pu		14. Race - Americ White, etc.	can Indian, Black,
ours after atural",	þ	3 Widowed 4 Divorced If Yes, Give Year or Dates: 15. Decedent's Education (Specify only highest grade or	ompleted) 16a. Deced	Yes 2 No specify:		Specify:	white ndustry
Baltimore, MD 21215-0036 permit. Pages I and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show injury or other traumatic event, the Medical Examiner must be notified at once.	Completed	Elementary/Secondary (0-12) College (1-4 o	or 5+) Stude			Educati	on
215-0 be filed v ntal Hygi rked oth	Be	17. Father's Name (First, Middle, Last) Ritchie Brooks			ame (First, Middle, North		
MD 21215-0036 d 2 should be filed within 7 th and Mental Hygiene. In 27 is marked other than summatic event, the Medica	To	19a. Informant's Name/Relationship (Type, Print) Laurie Gillespie – mother		ling Address (Street and Number I Hines Road, Fr			Zip Code) 1704
Ore, pgs 1 and tof Healt tof Healt is: If item		20a. Method of Disposition 1 Burial 2 Cremation 3 Removal from 5	State crematory or		Date 2-30-2009	20c. Location - City or	own, State Maryland
Baltimore, permit. Pages 1 an Department of Hea Important: If iter injury or other tr		4 Donation 5 Other Specify: 21. Signature of Funeral Service Licensee	22	2. Name and Address of Facility	Stauffer	Funeral Ho	me
Physician	7	23a. Part I. Enter the disease, or complications that cause failure. List only one cause on each line.		1621 Opossumtown or the mode of dying, such as cardinates			ryland 217 Approximate Interval Between Onset and
Mr. oftensel							Death
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	ner	or condition resulting in death) Due to (or as a conditions, if any, leading to immediate cause. The fundament of the conditions of the c	nsequence of):	m intoxication			50000
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3b. Was decedent pregnant in the past 12 months? 1 Yes 2 No 9 Unknown	1 Live birth 2 Fetal death 3 Ectopic pregnancy 4 Pregnant at time of death 5 Other (Specify) 9 Unknown	Month Day Year
Part II. Other significant conditions	contributing to death but not resulting in the underlying cause given in Part I.	23e. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown 24a. Was an autopsy prior to completion of cause of
25. Was case referred to medical	26.Place of Death (Check only	performed? death? 1 Yes 2 No 1 Yes 2 No
examiner? 1 ✓ Yes 2 No	Hospital: 1 Inpatient 2 V ER/Outpatient 3 DOA Other: Nursing H	lome 5 Residence 6 Other:
27. Manner of Death 1 Natural 5 Pending 2 Accident Investigati	on Fd 12/25/09 Fd 10:53 am 1 Yes 2X No u	d. Describe how injury occurred .nk
3 Suicide 6 X Could not determine	be (Specify) found in residence Fr	f. Location (Street and Number of Rural Route Number, City or Town, State) 5321 Hiners Rd ederick, MD
Chock only	ian: To the best of my knowledge, death occurred at the time, date and place, and due r:On the basis of examination and/or investigation, in my opinion, death occurred at the	

O.C.M.E.

21702

29d. Date signed (Month, Day, Year)

December 26, 2009

31. Date filed (Months Date Year) State Registrar

Carol Allan, MD

29b. Signature and title of certifier

Assistant Medical Examiner 111 Penn Street, Baltimore, MD 21201 32. Registrar's Signature

30. Name and address of person who completed cause of death (Item 23a)

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Physician /Medical **Examiner**

Funeral Director

28a-f show other traumatic event, the Medical Exactions dust be notified at

1 and 2 should be filed within 72 hours after death with Health and Mental Hygiene. em 27 Is marked other than "natural", or items 23a or permit. Pages 1 au Department of Hee Important: If item any injury or othe once.

Baltimore, Maryland 21215-0036

Physician /Medical Examiner

To the Hospital or Attending Physiclan: The law requires that the death certificate be executed within 24 hours after death. Box 68760 P.O. Records, Division of Vital

within 24 hours after death.

To the Funeral Director: A completely filled in by the fu

2. Date of Death December 19, 2009 2:20 A M 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Death 19108 North Pike Creek Place Montgomery Village Montgomery 8. Date of Birth (Month, Day, Year)
Oct. 27, 1 If Under 1 Year | If Under 24 Hrs. | 5. Social Security Number 6. Sex 9. Birthplace (State or Foreign 7. Age (In yrs. last birthday) 1 □ M 2 🗗 F Months Days Hours Min. 116-24-7736 79 1930 New York Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Montgomery Village Maryland Montgomery 1 ☐ Yes 2 ☐ No Director 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? United States 20886 19108 North Pike Creek Place Funeral 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian. Armed Forces?
1 ☐ Yes 2 🔀 No Black, White, etc. 1 Never Married 2 Married If Yes, Give Year or Dates: 1 ☐ Yes 2 🎛 No Specify: Completed by Specify: White 3 ₩ Widowed 4 Divorced 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Smithsonian College (1-4or 5+) Elementary/Secondary (0-12) Institute Reference Librarian 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Bertha T. Colgan Harold T. Wiley ပ္ 19a. Informant's Name/Relationship (Type. Print)
Mark Wiley Cleveland (Son) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 9908 Greenock Road, Silver Spring, MD 20901 20b. Place of Disposition (Name of cemetery, crematory or other place)
Metropolitan
Crematory 20c. Location - City or Town, State 20a. Method of Disposition Dec. 1 ☐ Burial 2 ☑ Cremation 3 ☐ Removal from State 4 Donation 5 Dother (Specify) 2009 Alexandria, Virginia 21. Signature of Sungral Service Licenses 22. Name and Address of Facility DeVol Funeral Home, M00689 10 E. Deer Park Drive, Gaithersburg, MD 20877 23a. Part 1. Emer the his * se, or complications that caused the shock, or he art raily e. List only one cause on each line. Approximate Interval Between Onset and Death wath. Do not enter the mode of dying, such as cardiac or respiratory arrest, Immediate Cause (Final disease or condition resulting in death) Adult Failure to Thrive Due to (or as a consequence of): Advanced Alzheimer's Dementia Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examine Due to (or as a consequence of): Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 🗆 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☒ No Month Year 4 ☐ Pregnant at time of death 5 Other (specify) 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? <u>م</u> Osteoporosis; Osteoarthritis; 1 ☐ Yes 2 X No 3 ☐ Probably 4 ☐ Unknown Completed Chronic Obstructive Pulmonary Disease 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? 1 ☐ Yes 2 ☐ No 1 ☐ Yes 2 XNo 25. Was case referred to medical Be 26. Place of Death (Check only one) Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 Nursing Home 5 🗷 Residence 6 Other (Specify) 1 Yes 2 No Certification: To 28a. Date of Injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28d. Describe how injury occurred 28c. Injury at Work? 1 🕅 Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide 29a, Certifier 1 X certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29b. Signature and title of certifier 29c, License number 29d. Date signed (Month, Day, Year) D04115 December 21, 2009 30. Name and address of person who completed cause of death (Item 23a) Type, Print) H. Robert Birschbach, M.D., 201 Russell Avenue, Gaithersbuerg, MD 20877 31. Date filed (Month, Day, Year) 32 Registrar's Signature State parke Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene 2009 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ William R. Carico P^{M} December 8:33 Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** 1317 Dent Road Churchton Anne Arundel 8. Date of Birth (Month, Day, Year) March 15, 5. Social Security Number If Under 1 Year If Under 24 Hrs. 7. Age (In vrs. last birthday) 9. Birthplace (State or Foreign **Funeral** 1 M 2 D F Months Days Hours Min. 229-46-2764 71 Director 1938 Vîrginia Usual Residence of Decedent permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hyglene.
Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examination. 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director Anne Arundel Maryland Churchton 1 Yes 2 X No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 1317 Dent Road 20733 U.S.A. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Was Decedent Ever in U.S. 11 Marital Status 14 Race - American Indian Armed Force Black, White, etc þ 1 ☐ Never Married 2 🔀 Married ☐ Yes 2 🔀 No 1 ☐ Yes 2 X No Specify: White If Yes, Give 3 Widowed 4 Divorced Completed Year or Dates 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) Plasterer Construction Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Dillon William Carico Laura C. Bobbitt 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Mary Carico/wife 1317 Dent Road Churchton, Maryland 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Date 1 Burial 2 X Cremation 3 Removal from State Baltimore Crematory 12/19/2009 Baltimore, Maryland 4 ☐ Donation 5 ☐ Other (Specify) Signature of Funeral Service Licenses 22. Name and Address of Facility John M. Taylor Funeral Home 147 Duke of Gloucester St., Annapolis, MD 21401 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Betwe shock, or heart failure. List only one cause on each line Immediate Cause (Final Onset and Death ARYNX Physician/ disease or condition resulting in death) Medical Due to (or as a consequence of) Examiner Sequentially list conditions. Examine if any, leading to immediate cause. Enter Underlying Due to (or as a consequence of) attending physician and for use as the burial-transit or Attending Physician; The law requires that the death certificate be executed Cause (Disease or iinium that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery ☐ Ectopic pregnancy in the past 12 months?

1 Yes 2 No Year Pregnant at time of death 5 Other (specify) ed by the a detached f 1 ☐ Yes 2 ☐ Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. cate has been signed I page 2 should be det 23e. Did tobacco use contribute to the cause of death? Completed by 3 Probably 4 □ Unknown 1 Yes 2 No 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an autopsy within 24 hours after death.

To the Funeral Director: After this certific completed filled in by the funeral director, Be 25. Was case referred to medica 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 No ပ္ 1 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of injury (Month, Day, Year) 28b. Time of Certificate: 27. Manner of Death 28c. Injury at 28d. Describe how injury occurred 1 Natural 5 Pending injury 2 No 1 Yes Accident Investigation 6 Could not be Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) Hospital Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. within 2 To the 1 only one) 29b. Signature and title of certifier Date signed (Month, Day, Year) 2009 Name and address of person who do leted cause of death (Item 23a) (Type, Prin ENSE YYI 31. Date filed (Month, Day, Year) State

DHMH 17 Rev 7/2009

Registrar

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Box 68760

P.O.

Records,

of Vital

Division

			1 - State of Maryland State of Maryland		artment of H tificate of D		-	201	09 4289	91			
			Decedent's Name (First, Middle, Last)		tinodio or E		2. Date of Dea	neg. No. —	3. Time of Dea				
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	Medic Examin		Martin P. Coblentz 4a. Facility Name (if not institution, give street and number)		4b. City. Town, or	Location of Death	ресешье	4c, County o					
	Examin							<i>'</i>					
-	Funeral		Northampton Manor Nursing Home 5. Social Security Number 6. Sex 7. Age (In yrs. last	birthday)	If Under 1 Year	ederick If Under 24 Hrs.	8. Date of Birt		ederick 9. Birthplace (State or Fo	oreian			
	Director		214-32-7547 ¹⊠м₂□F 77	Yrs.	Months Days	Hours Min.	May 10		Country) Maryland				
	- M	0	Usual Residence of Decedent										
	yland f shu	ctor	10a. State 10b. County 10c. City, 7	Town or Loc	cation	1			10d. Inside City Li				
	Mar 28a- notifi	Director		lerick					1 🗆 Yes 21	K J No			
	th the		10e. Street and Number		10f. Zip Code			10g. Citizen of W	nat Country?				
	th wil	Funeral	7914 Runnymeade Drive	T		702			States				
	r dea iner		11. Marital Status 12. Was Decedent Ever in U.S. Armed Forces? 1 □ Never Married 2 ☒ Married 1 □ Never Married 2 ☒ Married	13. V	Vas Decedent of His Yes, specify Cubar	spanic Origin? (Sp n, Mexican, Puerto	ecity Yes or No- Rican, etc.)		- American Indian, , White, etc.				
ဗ္ဗ	e flied within 72 hours after death with the Maryland tal Hygiene. A other than "natural", or items 23a or 28a-f show event, the Medical Examiner must be notified at	d by	1 ☐ Never Married 2 ☒ Married 1 ☐ Yes 2 ☒ No If Yes, Give Year or Dates.	1	☐ Yes 2 🛣 No	Specify:		Specify:	TTL days				
ŏ	nours natur ical l	Completed	Teal of Dates.	16a, Deced	ent's Usual Occupa	ation		16b. Kind of Bus	White				
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7	within giene er th the			Consu	ilting En	gineer		State Hi	ghway Admin	1.			
b	filed al Hy d oth	Be	17. Father's Name (First, Middle, Last)			18. Mother's Nam	e (First, Middle,	Maiden Surname)					
Maryland	should be file n and Mental H 7 is marked o raumatic eve	오	Walter Boyer Coblentz			Mary Bea	chley						
an.	2 should be th and Men 27 is marke traumatic		19a. Informant's Name/Relationship (Type, Print)	19b. Mailin	g Address (Street a	and Number or Run	al Route Number	r, City or Town, Sta	te, Zip Code)				
≥ .	and 2 s Health tem 27		Doris Coblentz/_Wife	7914	Runnymead	le Drive,	Freder	ick, Mar	yland 21702				
$\overline{}$	e 1 a of H if ite or oth		20a. Method of Disposition 1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State 20b. Plac	ce of Dispos	sition (Name of natory or other place	e) Dec 1	Date 4,2009	20c. Location - 0	City or Town, State				
Ē	Page ment o tant: If ury or			haven	Memorial			Frederi	ck, Marylan	d			
Baltimore,	permit. Page 1 and 2 Department of Health Important: If item 23 any injury or other to		21. Signature / uneral Service Licensee	22. S i	Name and Addres	s of Facility	omas P	Δ	Maryland 21				
"	⊈ <u>₽ 9</u>	17	Sall Olympur						Maryland 21	L702			
23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only on cause on each line. Immediate Cause (Final disease or condition resulting in death) Examiner 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only on cause on each line. Encephalopaly Due to (or as a insequence of the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only on cause on each line. Due to (or as a insequence of the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only on cause on each line. Due to (or as a insequence of the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only on cause on each line. Proproximate Interval Between the part of the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only on cause on each line. Proproximate Interval Between the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only on cause on each line. Proproximate Interval Between the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only on cause on each line. Proproximate Interval Between the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only on cause on each line. Proproximate Interval Between the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only on cause on each line. Proproximate Interval Between the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only on the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only on the mode of dying, such as cardiac or respiratory are the mode of dying. Proproximate Interval Between the mode of dying are the mode of dyin													
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	sit sit	Examiner	cause. Enter Underlying	es of,	O								
	ecute and I-tran	Exal	Cause (Disease or iinjury that initiated events resulting in death) Last C. Due to (or as a consequen	ice of:									
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760	death certificate be executed re attending physician and ed for use as the burial-transit	ledical	d										
Box 68	certifi nding use a	<u>N</u>	IF FEMALE: 23b. Was decedent pregnant 23c. If yes, outcome of pregnance					23d Date	of delivery				
ŏ	atter	icia	in the past 12 months? 1 ☐ Live Birth 2 ☐ Fetal d 1 ☐ Yes 2 ☐ No 4 ☐ Pregnant at time of dea		Ectopic pregnancy Other (specify)	У		Mont					
<u>.</u>	he de y the iched	hys	9 Unknown										
P.O.	r requires that the death certific been signed by the attending I should be detached for use as	y P	Part II. Other significant conditions contributing to death but not resulti	ing in the ur	nderlying cause give	en in Part I.	23e. Did to	bacco use contrib	ute to the cause of death	h?			
ŝ,	uires n sign	ed t					1 🗆 🕆	∕es 2□No 3	Probably 4 🗌 Unki	nown			
oro	v req	olet					24a. Was a		ere autopsy findings avail				
Sec.	he lav te hat age 2	Completed by Physician/M						rmed? de	or to completion of cause ath? ☐ Yes 2 ☐ No	e of			
<u>e</u>	an: T tifica tor, p	BeC	25. Was case referred to medical		26. Pla	ace of Death (Chec	1 \(\superset \text{Yes}\)	2 NO	_ res Z _ No				
<u> </u>	lysici is cel direc	To E	examiner? 1 ☐ Yes 2 D No Hospital: 1 ☐ Inpatient 2 ☐ EF	R/Outpatient	t 3 □ DOA Othe	r: 4 🕅 Nursing Ho	ome 5 🗆 Resid	ence_6 Other	(Specify)				
ō	ng Ph ter th neral		Manual Davidon	Bb. Time of injury	28c. Injury work	at		ow injury occurred					
on	endin sath. or: Aff	fica	2 Accident Investigation	injury		yes 2 □ No							
Division of Vital Records,	r Att	Certificate:	3 ☐ Suicide 6 ☐ Could not be 4 ☐ Homicide determined 28e. Place of Injury - At home building, etc. (Specify)	e, farm, stre	et, factory, office		28f. Location (S City or Tow		or Rural Route Number,				
á	italo Irsaf ral Di						01.7 01 1011			()			
	To the Hospital or Attending Physician: The law requires that the within 24 hours after death. To the Funeral Director. After this certificate has been signed by the completed filled in by the funeral director, page 2 should be detached.	29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.											
	thin 2 thin 2 the I	Ψ	only one) 3 L Certifying Nurse Practioner: To the best of my kr	nowledge, d	eath occurred at the	time, date and place	ce, and due to the	cause(s) and man	ner as stated.				
	7 . i≥ 6 0		29b. Signature and title of certifier		29c, License			29d. Date signed (viontn, Day, Year)				
7)-) (T = 5		11		11					
	12		30. Name and address of person who completed cause of death (Item 23		Tou !	House	Ave	, Fred	ench, M	(1)			
	Stat Registra		31. Date filed (Month, Day, Year) 32. Registrar's Signature IEC 15 2009	A.	park								

	Am	en	d PI line a-b,	ase Type or 25, per Mi State o	Print in	Black II 1/25/10 id / Depa	ndelible) TT artment	e Ink	. Ens ı ealth a	ure A	III Copie Mental Hy	es Ai	r <mark>e Leg</mark> ie	ible.	
		•	1 - State Registrar				rtificate							09	42892
	Physicia	ın/	1. Decedent's Name (First, Midd	e, Last)							2. Date of D	eath		Year.	3. Time of Death
	Medic		RUTH		ETHERED	GE					Decemb				1:10 А м
	Examir	er	4a. Facility Name (if not institution Frederick Me				4b. City, To Fre	own, or Leder:		f Death			4c. County Fred	of Death leric	
	Funeral Director		5. Social Security Number 578-34-1352	6. Sex 1 ☐ M 2 🖾 F	7. Age (In yrs. 84		If Under 1 Months	Year Days	If Under 2 Hours	24 Hrs. Min.	8. Date of B (Month, D April		1925		nplace (State or Foreign ntry) ington, DC
	d iow it	_	Usual Residence of Decedent 10a. State 10b. County	,	10c Ci	ty, Town or Lo	cation								10d, Inside City Limits
	arylan a-f sh fied a	Director													1 X Yes 2 No
	or 28		Maryland Monts 10e. Street and Number	gomery		Saither	10f. Zip C	code				10a.	Citizen of V	What Cou	intry?
	with s 23a ust b	Funeral	446 Girard Str	eet, #101			2	2087	7				Unite	ed St	tates
	death items ner m		11. Marital Status	12. Was Dec	edent Ever in U.	S. 13.	Was Decedent of Hispanic Origin? (Specify Yes of If Yes, specify Cuban, Mexican, Puerto Rican, etc.				cify Yes or No	No- 14. Race - Ameri Black, White,			
36	after	d by	1 ☐ Never Married 2 ☐ Ma 3 ☐ Widowed 4 🖾 Divorce	. If Yes, Gir			1 ☐ Yes 2 ☑ No Specify:			, , , , , ,		Specify:			
9	72 hours after death with the Maryland n "natural", or items 23a or 28a-f show ledical Examiner must be notified at	lete		Year or D ent's Education	ates. WW I		dent's Usual (Occupat	tion			16h	Kind of Bu		ite
21215-0036	n 72 h e. ia n "n Medi	Completed	(Specify only high Elementary/Seconday (0-12)	est grade completed College (*		(Give	kind of work o O NOT use re	done du	ring most	of worki	ng	100	Talle of De	40111000 11	ladotty
2	within ygiene.		12		,	Leg	al Sec	reta	ary				L	aw	
and	be filec ental H ked ot c even	To Be	17. Father's Name (First, Middle,	,					18. Mothe	r's Name	e (First, Middle				
Maryland	1 and 2 should be filed within 72 hours of Health and Mental Hyglene. Item 27 is marked other than "natur other traumatic event, the Medical		Grant1 19a. Informant's Name/Relations		cn	10h Mailin	na Address (C	Street on	ad Numba	e or Dura	Ethel I Route Numb		Kidw		Cadal
Ma	12 shouth and the sho	- 3	Juliette Anders		er	7									D. 20877
re,			20a. Method of Disposition		20b.	Place of Dispo	sition (Name	of	- 1		Date		Location -		
imo	Page 1 nent of I ant: If it		1 ☐ Burial 2 🔀 Cremation 4 ☐ Donation 5 ☐ Other		I State	zopoli Zopoli				12/	24/09	A ₁	Lexand	dria	, Virginia
Baltimore,	permit. Page Department of Important: If any injury or ong.		21. Signature of Funeral Service	License	0.00	22	2. Name and A	Address	of Facility	DeV	ol Fun	era1			
	a •		Medie	ex/V			-						rsbu	rg, l	MD. 20877
			23a. Part 1. Enter the disease, c shock, or heart failure. List Immediate Cause (Final	only one cause on ea	ach line.							irrest,			Approximate Interval Between Onset and Death
Morning	Physician/ ≽Medical		disease or condition resulting in death)	a. Due to	Sign (or as a conseq ATR	D (1)	1 (-13	١.							to with
	Examiner	L	Sequentially list conditions,	h	ATR	1100	FIBR	216	LIA	7 10	7			-	YEARS.
	sit sit	Examiner	if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury	Due to	(ur as a curreed	usnes o'):			0	4.1	1 1/2		1		•
)	executed ian and irial-transit	Еха	that initiated events resulting in death) Last	c. Due to	(or as a conseq	uence of):		CERTIFI	CATION	HOVE	er our en	YALINE	R		
09	te be e hysicia he buri	dical		d					1					-	
Box 68760	Physician: The law requires that the death certificate be this certificate has been signed by the attending physici al director, page 2 should be detached for use as the but	Physician/Medica	IF FEMALE:	23c If yes ou	tcome of pregna	ancv									
XO	atten atten	iciar	23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☒ No	1 🔲 Live	Birth 2 Fet	aldeath 3 🛚	Ectopic pre Other (spec						Mo	te of deliv inth	Day Year
Э.В	the de	hys	9 Unknown	g 🗌 Unk	nown										
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rds	equire een si rould l	ted	1031 00000	(,,)	0-10,0	1/		~			1 L	Yes			bbably 4 🗌 Unknown
000	has b	Completed by				-						s an opsy formed?	F	Nere auto prior to co death?	opsy findings available ompletion of cause of
H.	n: The ficate r, pag		25, Was case referred to medical						- (5 "	. (0)	1 Tyes	2 😿			2 🗆 No
/ita	sicial coerti	To Be	examiner?	Hospital:	Inpatient 2	EP/Outpation		1 - :	e of Deatl		me 5 \square Res	.: هم مدم د	6 D O#b	au (Canaid	2.4
of/	ig Phy ter this neral c		27. Manner of Death	28a. Date		28b. Time of injury		Injury a			28d. Describe				<u>y)</u>
on	endin eath. or: Aft	fica	1 Natural 5 Pend 2 Accident Invest 3 Suicide 6 Could	igation	in, bay, reary	ingury	М		'es 2 🗆	No					
Division of Vital Records, P.O.	l or Att after d Direct I in by I	Certificate:	4 Homicide determ	nined 28e, Place	of Injury - At he ing, etc. (Specif		eet, factory, o	office			28f. Location City or To			er or Rura	al Route Number,
	To the Hospital or Attending Physician: The law requires that the death certificate be within 24 hours after death certificate be within 24 hours after death. To the Luneral Director: After this certificate has been signed by the attending physici completed filled in by the funeral director, page 2 should be detached for use as the but the but the funeral director.	Medical		g Physician: To the la											ed. ause(s) and manner stated.
	the H thin 24 the F mplet	Me	only one) 3 Certifyin	g Nurse Practioner:			death occurred	d at the t	time, date			he caus	e(s) and ma	anner as s	stated.
	15+1							icense r		22	?	29d. [Date signed 2 / 2	a (Month,	uay, rear)
			39 Name and address of person	who completed cau	se of death (Iten	n 23a) (Type, F	T Desu	17.	FRE	NP.	2106	MD	21	170	2.
	Sta		31. Date filed (Month, Day, Year) DEC 22	32 F	Registrar's Signa		Wed .	٧/		<i>-,</i> 0 -	7				
	Registra	ar	ロビ とな	ZUUY LE	was 1	3. 14 a	C. Carrie								

			State of Maryland / Dep	artment of Health and N	⁄lental Hygien	е	
			1 - State Registrar Ce.	rtificate of Death	Reg. N	.2009	42893
	Physicia Medic		1. Decedent's Name (First, Middle, Last) Mary Chellammal Edwin		2. Date of Death Month December	^{)ay} 19, 2009	3. Time of Death 2:00 a M
	Examin		4a. Facility Name (if not institution, give street and number)	4b. City, Town, or Location of Death		lc. County of Death	
فرر	The state of the s		14011 Wildwood Drive	Silver Spring		Montgo	mery
	Funeral Director		5. Social Security Number 216-13-3470 6. Sex 1	If Under 1 Year If Under 24 Hrs. Months Days Hours Min.	8. Date of Birth (Month, Day, Year) June 21,	9. Birth C <i>ou</i> 1921 Indi	nplace (State or Foreign (ntry) La
	d wo t		Usual Residence of Decedent 10a. State 10b. County 10c. City. Town or Lo				101111111111111111111111111111111111111
	arylan a-f sh fied a	Funeral Director	1				10d. Inside City Limits 1 Yes 2 No
	he Mis or 28.	Dire	Maryland Montgomery Silve 10e. Street and Number	r Spring 10f. Zip Code	10a. C	Citizen of What Cou	
	with t	eral	14011 Wildwood Drive	20905	USA		
	death items ier m	Fun	11. Marital Status 12. Was Decedent Ever in U.S. 13. Armed Forces?	Was Decedent of Hispanic Origin? (Spe If Yes, specify Cuban, Mexican, Puerto	ecify Yes or No-	14. Race - Ameri	
36	after or II", or xamir	d by	1 ☐ Never Married 2 ☐ Married 1 ☐ Yes 2 ☒ No If Yes, Give	1 ☐ Yes 2 🖾 No Specify:	r nour, otory	Black, White	
ဝို	atura cal E	etec	Tear of Bates.	dent's Usual Occupation	16h	Kind of Business I	sian Indian
215	n 72 h an "n Medi	Completed	(Specify only highest grade completed) (Give	kind of work done during most of work O NOT use retired)	ing	Kind of Busiless II	ndustry
7	l withi		10 Ho:	memaker	O _V	wn Home_	
land	i be filed fental Hy rrked ott ric even	To Be	17. Father's Name (First, Middle, Last) Arul Dawson		e (First, Middle, Maidel al Vellakka	,	
Baltimore, Maryland 21215-0036	permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.			ng Address (Street and Number or Rura 1 Wildwood Drive,			
nore,	age 1 and and of He it. If item			matory or other place) Dec.	23.	Location - City or 1	Town, State
Ħ	mit. Partme bartme bortan injur.		4 Donation 5 Other (Specify) 21. Signature of Funeral Service Licensee 22.	erv !			
ä	permit Depar Impor any in	di d	James & Cooling	Name and Address of Collins Francis 500 University Blue	d. W., Si	lver Spri	ng, MD 2090
			23a. Part 1. Enter the disease, or complications that caused the death. Do not ent shock, or heart failure. List only one cause on each line. Immediate Cause (Final	er the mode of dying, such as cardiac	or respiratory arrest,		Approximate Interval Between Onset and Death
	Physician/		disease or condition resulting in death) Cardiopulmonary A: Due to (or as a consequence of):	rrest			Onset and Death
	Examiner		Metastatic Bladde	r Cancer			2 yrs.
	d sit	Examiner	Seque tially list conditions, if any, leading to immediate cause. Enter Underlying Due to (or as a consequence of):				3
)	ate be executed hysician and the burial-transit	Exar	Cause (Disease or linjury that initiated events c. resulting in death) Last Due to (or as a consequence of):				
09	e be ey	dical	d				
876	ificate ng phy as the	Med	IF FEMALE:		-		
Box 687	eath certifice attending p I for use as f	jan/	23b. Was decedent pregnant 23c. If yes, outcome of pregnancy 1 ☐ Live Birth 2 ☐ Fetal death 3 ☐	Ectopic pregnancy		23d. Date of deli	
B	that the deaned by the at	Physician/Me	1 ☐ Yes 2 🕱 No 4 ☐ Pregnant at time of death 5 ☐ 9 ☐ Unknown	Other (specify)		Month	Day Year
P.0	that the ned by details	by P	Part II. Other significant conditions contributing to death but not resulting in the	ınderlying cause given in Part I.	23e. Did tobacco	use contribute to	the cause of death?
ds,	v requires the special special be considered to the special sp		Diabetes Mellitus, Hypertension, Hy	pothyroidism	1 🗆 Yes 🔞	2 tc No 3 □ Pm	obably 4 🗆 Unknown
cor	aw rec as bee 2 sho	Completed			24a. Was an autopsy	prior to co	opsy findings available ompletion of cause of
Ř	Physician: The law this certificate has al director, page 2 ?	Con			performed?	death?	2 🗆 No
ta	ician: sertific ector,	Be	25. Was case referred to medical examiner? Hospital:	26. Place of Death (Check	(only one)		
Ž	Physic ruthis or this or the direction of the control of the contr	∋: To	1 Inpatient 2 ER/Outpatie 27. Manner of Death 28a. Date of injury 28b. Time o	nt 3 □ DOA 4 □ Nursing Ho	me 5 🔼 Residence 28d. Describe how inju		fy)
ou o	I or Attending Ph after death. Director: After th I in by the funeral	Certificate:	1 Matural 5 ☐ Pending (Month, Day, Year) injury 2 ☐ Accident Investigation 3 ☐ Suicide 6 ☐ Could not be	work? M 1 Yes 2 No	Zou. Describe flow lift	iry occurred	
Division of Vital Records, P.O.	tal or Att rs after d al Direct ed in by i	al Certi	4 Homicide determined 28e. Place of Injury - At home, farm, str building, etc. (Specify)	eet, factory, office	28f. Location (Street a City or Town, Stat		al Route Number,
	To the Hospital or Attending Physician: The law requires that the death certificate be executed within L2 thous after death. To the Funeral Director: Hate this certificate has been signed by the attending physician and completed filled in by the funeral director, page 2 should be detached for use as the burial-transit	Medical	29a. Certifier (Check conly one) 1 ☐ Certifying Physician: To the best of my knowledge, death conly one) 1 ☐ Certifying Physician: To the best of my knowledge, death conly one) 1 ☐ Certifying Physician: To the best of my knowledge, death conly one)	tigation, in my opinion, death occurred at	the time, date and place	ce, and due to the ca	ause(s) and manner stated.
	Som the sound of t		29b. Signature and title of certifier	29c, License number D56147	29d. D	late signed (Month,	Day, Year)
			30. Name and address of person who completed cause of death (Item 23a) (Type, I Nasreen Kango, MD 7701 Carroll Av	Print) enue, Takoma Park,	MD 20912		1
	Stat Registra		31. Date filed (Month, Day, Year) DEC 2 2 2009 Sensor A. Stignature	es.			

State of Maryland / Department of Health and Mental Hygiene 1 _ For State Certificate of Death

Physician	
/Medical	
Examiner	

Funeral Director

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any Injury or other traumatic event, I'm Micral Eval: Instituted at once.

Baltimore, Maryland 21215-0036

Physician /Medical Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit Division of Vital Records, P.O. Box 68760,

		 State Registrar 				Ce	rtificat	e of I	Death)	1	Reg. No	.20	nα	1,2891	
		Decedent's Name (First)	t, Middle, L	ast)							2. Date of Dea	ath	20	U)	3. Time of Death	
sician		Joyce B. 1	Fox								Decemb	er Da	77.20	Year 0°9°	9:00 A M	
edical							T 41 00	7	1 1	(D 4h						
miner	п	4a. Facility Name (If not in			,				r Location	of Death			. County o			
		8100 Connec					Chev	-					lontg			
ral		5. Social Security Number	f 6.	Sex 1 ☐ M 2 🖾 F	7. Age (In yrs	. last birthday)	If Under Months	1 Year Days	If Under Hours	r 24 Hrs. Min.	8. Date of Birt (Month, Da	h y, <i>Year</i> ,	9. Birthplace (State or Fore Country)			
tor		075-20-1166		ILIM ZAIF	8	2 Yrs.		,-			09/24/	192	7		ew York	
	- 1	Usual Residence of Deced	dent													
f .	- 1	10a. State 10b.	County		10c. C	ity, Town or Lo	ocation							10	d. Inside City Limits	
غ ا		Maryland M	ontgo	merv	Ch	evy Chase						1A Yes 2 No				
Director	Í	10e. Street and Number				10f. Zip Code						10g. Ci	itizen of W	hat Count	ry?	
	i	3100 Connect:	icut	Δυρμιο :	1412			2	0815					USA		
Filheral	}		Tout		edent Ever in U	10 10	Was Doos			rigin? (Cne	oify Von or No		14 Dece	- America	n Indian	
1.5		11. Marital Status		Armed Fo	orces?	7.3.	If Yes, spe	cify Cuba	an, Mexica	in, Puerto l	ecify Yes or No- Rican, etc.)			k, White, et		
2		1 Never Married 2		If Yes, G	ve		1 ☐ Yes	2 🔀 No	Specify	<i>'</i> :			Specify:		White	
		3 X Widowed 4 ☐ Di	olvorcea	Year or D	ates:											
Completed		15. Do	ecedent's l	Education grade completed)		(Give	dent's Usu kind of wo	rk done o	durina mos	st of workir	na i	16b. k	Kind of Bus	siness/Inde	ustry	
2		Elementary/Secondary ((0-12)	College (1-4or 5+)	life.	DO NOT u	se retired	d) "							
ج ا				4		Ch	emica	1 Ma	nufac	cture	r		Mar	nufac	turing	
a B		17. Father's Name (First, I	Middle, Las	st)					18. Moth	ier's Name	(First, Middle,	Maider	n Surname	e)		
P		Mur	ry Bo	xer							Edna Ro	thm	an			
-		19a. Informant's Name/Re				19b. Maili	na Address	(Street	and Numb	per or Rura	al Route Numbe	er. City	or Town. 5	State. Zip i	Code)	
	1	Deborah Fox.	,			1	. *				otomac,			_ ` `_	0854	
	1	20a. Method of Disposition		, iii C L	20h						ate		ocation - (
		20a. Metriod of Disposition 1⊠ Burial 2 ☐ Cren		☑Removal from	State 200.	Place of Dispo cemetery, crea	matory or o	ther plac	ce)	D	ate	200, L	.ocalion - C	Sity of 10v	vii, State	
		4☐Donation 5☐O				11wood	Ceme	terv		12/20	/2009	Far	mingd	lale.	New York	
once		21 Signature of Funeral 5	Service Lic	ensee		2	2. Name ar	d Addres	ss of Facil	ity	L DIREC	m T A	N TN	TC.		
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	1	23a. Part 1. Enter the dies	se, or co	mplications that									, III		Approximate	
	1	shock, or heart failur	re. List onl	ly one cause on e	each line.			,	9,		,	,			Interval Between Onset and Death	
an	1	disease or condition Emphysema a. Emphysema														
al	1	Due to (or as a consequence of):														
er	1	Cognoptially list conditions		b.												
Examiner		Sequentially list conditions if any, leading to immediat cause. Enter Underlying	te	Due to	(or as a conse	quence of):										
Ξ		Cause (Disease or injury that initiated events	1													
×		resulting in death) Last		Due to	(or as a conse	quence of):							-			
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Me		IF FEMALE:		220 If you ou	tcome of pregr	10001/										
1.5		23b. Was decedent pregn in the past 12 months		1 🗆 Live	birth 2 Fet	al death 3[☐ Ectopic p		У			1	23d. Date Mon	of deliver	ry Day Year	
S		1 ☐ Yes 2 ☐ No		4 ∐ Preg 9 □ Unki	nant at time of	death 5	Other (st	ecify) _					IVIOI		Jay 16a	
Physicial		9 🗌 Unknown										-				
>		Part II. Other significant of		contributing to d	eath but not re	sulting in the u	nderlying c	ause give	en in Part	l.	23e. Did to	bacco	use contri	bute to the	e cause of death?	
Completed by	(Crohn's Dise	ase								1 🔯 Y	es 2	! □ No	3 ☐ Proba	ably 4 🗌 Unknown	
ete	1	Hypertension								-	24a. Was	on	0.41- 14	loro out-	ov findings overlights	
9		ily per cents ion									autop	SV	l pi	rior to com	sy findings available apletion of cause of	
Ö		Chronic Ster	oid U	Jse							1 □ Yes	rmed? 2 🖾 No	0 1	eath? □Yes :	2 □No	
Be (25. Was case referred to r examiner?							26. Plac	e of Death	(Check only o					
		1 ☐ Yes 2 X No		Hospital: 1 🗆	Inpatient 2] ER/Outpatie	nt 3 🗆 DO	Othe	er: 4□ N	lursing Hor	me 5 🔀 Resid	lence	6 □ Othe	r (Specify)	
	1	27, Manner of Death		28a. Date	of Injury	28b. Time o		8c. Injur			28d. Describe h				·	
ţi			Pending investigati		ith, Day, Year)	Injury	М		k? Yes 2.⊑]No						
2		3 ☐ Suicide 6 ☐	Could not	be as Place	of Injury - At h	nome farm str	reet factors	office			28f Location /6	Stroot a	nd Numbe	r or Pumi	Route Number,	
	1	4 Homicide	determine	build	ing, etc. (Spec	ify)	oot, lactor,	, 011100		1	City or Tou	ın, Stat	e)	ii oi nuiai	noute Number,	
ပိ	-	00.0.1		_1												
Cal		(Check only 2 M	ertifying F ledical Ex	Physician: To the aminer: On the b	e best of my kn pasis of examin	owledge, deat ation and/or in	th occurred ovestigation	at the tir	me, date a pinion, de	and place, a	and due to the	cause(:	s) and mai	nner as sta	ated. the cause(s)	
Medical Certification: To		one)		and mar	ner stated.			,, 0	,			Jaco al	p.uvo, a			
Ž		29b. Signature and title of	certifier	_			290	. Licens	e number			29d. Da	ate signed	(Month, D	Day, Year)	
		-	/,	110	1110	1112		D23	170			De	cembe	er 18	, 2009	
	-	20 Name and Aller	1	1/250	UNK	m 22=1/F=	Drint\									
		30. Name and 6 46ress of p Gita C. Bak			,	, , , , ,		nad	Ro+1	heeda	Marul	and	208	314		
							711.000	oau,	חברו	resua	, raly1	and		714		
State		31. Date filed (Month, Day,		100 32.	Registrar's Sign	ature	K.S									
istrar		DEC 2	0 A CL	JUJ KEN	euro p	7. 749 W	-									

Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month Anthony Garfield Fitzgerald 2009 <u>December</u> Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death Shady Grove Adventist Hospital Rockville Montgomery Social Security Number 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Yea March 23, Funeral 6. Sex 1 X M 2 □ F 7. Age (In vrs. last birthday 9. Birthplace (State or Foreign Months Days Hours Min Virginia **Director** 225-44-0161 1936 March Usual Residence of Decedent iral", or items 23a or 28a-f show Examiner must be notified at 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director 1 Yes 2 X No Maryland | Montgomery <u>Gaithersburg</u> 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 8101 Bondage Drive 20882 within 72 hours after death 11. Marital Status 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian Armed Forces?

1 X Yes 2 No Black. White, etc. þ 1 Never Married 2 X Married Maryland 21215-0036 1 ☐ Yes 2 X No Specify: "natural", Completed 3 Divorced 4 Divorced Specify: Year or Datesunknown White permit. Page 1 and 2 should be filed within 72 hour Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natur any injury or other traumatic event, the Medical 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) 12 P<u>roduce Manager</u> Grocery Store Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Fred Calvin Fitzgerald Lena Elizabeth Wealthy 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) <u>Anna Mae Fitzgerald, wife</u> Bondage Drive, Gaithersburg, Maryland 20882 Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Date 1 X Burial 2 Cremation 3 Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Parklawn Memorial Park 12/21/2009 Rockville, Maryland 21. Signature of Funeral Service Lic ee 22. Name and Address of Facility Molesworth-Williams Funeral Home 21521 26401 Ridge Road, Damascus, Maryland 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Retween Immedia. Cause (Final disease or ition resulting in death) Onset and Death Physician/ Septic Shock (Gram Negative Sepsis) Medical Due to (or as a consequence of Examiner Right Sided Lobar Pneumonia days Sequentially list conditions. Examine if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Due to (or as a consequence of): sician and burial-transit The law requires that the death certificate be executed that initiated events resulting in death) Last Due to (or as a consequence of): attending physician for use as the buria Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ in the past 12 months?
1 ☐ Yes 2 ☐ No Month Day Pregnant at time of death been signed by the a should be detached 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Completed 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 X Unknown Were autopsy findings available 24a. Was an page 2 s prior to completion of cause of death? autopsy Yes 2 X No 1 Yes 2 No To the Hospital or Attending Physician: 25. Was case referred to medical Certificate: To Be 26. Place of Death (Check only one) examiner? Other: 1 Tes 2 🛛 No 4 Nursing Home 5 Residence 6 Other (Specify, 1 X Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA After this filled in by the funeral 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred X Natural 5 Pending injury work? 1 ☐ Yes 2 ☐ No 24 hours after death Funeral Director: A Accident Investigation Suicide 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 28f. Location (Street and Number or Rural Route Number Medical 2ga Certifier 🗓 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. сотретер 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 0 · O · D0066656 December 15, 2009 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 10+1 9901 Medical Oluwapelumi 0. Fakeye, Center Drive, Rockville, Maryland 20854 31. Date filed (Month 32. Registrar's Signature State Market som

DHMH 17 Rev 7/2009

Registrar

Please Type or Print in Black Indelible Ink, Ensure All Copies Are Legible.

Amend Item 24 a per phys G899 1/14/10 dk
State of Maryland / Department of Health and Mental Hygiene State Registrar Reg. No. 2 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ December 10,2009 Fritz 2:40A M Bertha Rickert Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death 6474 Saddlebrook Lane Frederick Frederick Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** 1 ☐ M 2 🛣 F Months Days Hours Min. (Month, Day, Year Country Director 192-20-1648 ĺ928 Sept. Pennsylvania Usual Residence of Decedent 28a-f show Ħ 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director Examiner must be notified 1 🗌 Yes 2 😿 No Maryland Frederick Frederick 10e. Street and Number 10f. Zip Code ō 10a. Citizen of What Country? 23a with Funeral 6474 Saddlebrook Lane 21701 <u>United States</u> items 72 hours after death 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-11. Marital Status 14. Race - American Indian. Armed Forces?
1 ☐ Yes 2 ☒ No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Black, White, etc. 9 þ 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 Tes 2 No Specify: If Yes, Give 3 ₩ Widowed 4 Divorced Specify: "natural" Completed Year or Dates White traumatic event, the Medical 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) e 1 and 2 should be filed within 72 P of Health and Mental Hygiene. If item 27 is marked other than "n or other traumatic event, the Medi (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) Sunnybrook Ballroom Hostess Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) ဂ္ Wilmer Hipple Porter Lavina Ester Nonemaker 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Jack W. Rickert/ son <u>6474 Saddlebrook Lane,Frederick, Maryland 21701</u> 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State permit. Page 1 s Department of H Important: If ite any injury or ot Date cemetery, crematory or other place 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) vn Cemetery Dec.16.2009 Pottstown, Pennsylvani 22. Name and Address of Facility Stauffer Funeral Home, PA Pottstown Cemetery Signature of Funeral Service Line 1621 Opossumtown Pike, Frederick, MD 21702 Part T. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause of each line. 23a. Part Approximate Interval Betweer Onset and Death Immediate Cause (Final malignant melanoma Ph_sician/ disease or condition resulting in death) Medical Examiner Due to (or as a consequence of) Sequentially list conditions if any, leading to immediate cause. Enter Underlying Due to (or as a consequence or) Exam use as the burial-transit Cause (Disease or iinjury and that initiated events resulting in death) Last Due to (or as a consequence of): attending physician Physician/Medical law requires that the death certificate be P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy Į, in the past 12 months?

1 Yes 2 No 5 Other (specify) Month Day Year Pregnant at time of death 4 ☐ Pregnant 9 ☐ Unknown signed by the a a | Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by Diabetes Records, 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown should Hypertension 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☐ No 24a. Was an page 2 Pankinkons disease performed? Hospital or Attending Physician: The certificate Yes 2 X No 25. Was case referred to medical examiner?
1 ☐ Yes 2 ☐ No Vital funeral director. Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 XOther (Specify) Residence Hospital: မ 1 Inpatient 2 ER/Outpatient 3 IDOA this of 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at work? 1 ☐ Yes 2 ☐ No Certificate: 28d. Describe how injury occurred After injury Natural 5 Pending Division Investigation Accident after death filled in by the 6 Could not be Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined City or Town, State) 24 hours a Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. completed 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check within 2 To the I only one)

State

29b. Signature and title of certifie

31. Date filed (Month, Day Y

Registrar DHMH 17 Rev 7/2009 ian lowely m &

Registra's Signature

and address of person who completed cause of death (Item 23a) (Type, Print)

iarkousic

29c. License number

9093 Ridgefield Dr. Suite 104 Frederick, MD

anker

DAAB

29d. Date signed (Month, Day, Year)

Leanbe 10, 2009

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day **Physician** Month Year Michelle Gyamerah A^{M} /Medical December 2009 4:50 4a. Fecility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Holy Cross Hospital Silver Spring Montgomery 5. Social Security Number If Under 1 Year If Under 24 Hrs. 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** 1 ☐ M 2 🖾 F Yrs. Director None Nov. 28, 2009 Maryland Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits 28e-t show r than "natural", or Itams 23a or 28e-t shov the Mudical Extra Instrumst be notified at 1 TYes 2KiNo Directo Maryland Prince George's <u>Beltsville</u> the 10e. Street and Number 10g. Citizen of What Country? 10f. Zip Code 11445 Cherry Hill Road #203 death Funeral 20705 United States 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Black, White, etc. filed within 72 hours after 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: 1 Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☑ No Specify: þ Specify: **Black** 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business/Industry (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) .. Pages 1 and 2 should be filed w tment of Health and Mental Hygier tant: It item 27 is marked other th ijury or other treumatic event, Illa None None 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be 2 Philip Jubor Audrey Aubyn 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Philip Jubor/Father 11445 Cherry Hill Road #203; Beltsville, ND 20705 20b. Place of Disposition (Name of cometery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, Stete Important: It it any injury or o once. rtment of 1 ☐ Burial 2 X Cremation 3 ☐ Removal from State ¹ 4 □ Donation 5 □ Other (Specify) Ft. Lincoln Crematory 12/22/09 Brentwood, Maryland permit. 22. Name and Address of Facility Simple Tribute 21. Signature of Funeral Service Licenses 1040 Rockville Pike; Rockville, MD 20852 23a. Part1. Enter the disease or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition Physician Respiratory Insufficiency resulting in death) /Medical Due to (or as a consequence of) **Examiner** Severe Pulmonary Interstitial Emphysema Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner death certificate be executed Mechanical Ventilation the attending physicien and hed for use as the burial-tran Due to (or as a consequence of): 68760. Physician/Medical Prematurity 23 Weeks Gestation IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? Month Year signed by the al 4☐Pregnant at time of death 5 Other (specify) P.0. 1 ☐ Yes 2 ☒ No 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, eq pinous Sepsis, Pulmonary Hypertension, Hypotension, 1 ☐ Yes 2X No 3 ☐ Probably 4 ☐ Unknown peen Adrenal Insufficiency 24a. Was an autopsy performed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☒ Yes 2 ☐ No page 2 has certificate 1 🔀 Yes 2 No Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 X Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 1 ☐ Yes 2 X No 2 this 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? Certification: 28d. Describe how injury occurred After 1 X Natural 5 Pending investigation s after death. 1 ☐ Yes 2 ☐ No the f 2 Accident 3 Suicide 6 Could not be Płace of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by determined 4 Homicide ö within 24 hours a To the Funerel I Hospitel 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifie Medical To the 29b. Signature and title of certifie 29c. License number 29d. Date signed (Month, Day, Year) D0031315 W.0 12-12-09 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Fabio Olarte, M.D. 400 West 7th Street; Frederick, ,D 21701 31. Date filed (Month, Day, Year) 32. Registrar's Signature State 22 Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death December 2009 3:00 a Lois Ruth Greenspan 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Washington Adventist Hospital Montgomery Takoma Park 8. Date of Birth Social Security Number If Under 1 Year If Under 24 Hrs. 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign Days 1 □ M 2 🕏 F Hours 06/28/1939 Mary Land 577-50-6015 70 Usual Residence of Decedent 10b. County 10a. State 10c. City, Town or Location 10d. Inside City Limits 1 🖾 Yes 2 🗆 No Silver Spring Maryland | Montgomery 10e. Street and Number 10f, Zip Code 10g. Citizen of What Country? 12509 Summerwood Drive 20904 USA 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian. Black, White, etc. 1 Never Married 2 X Married 1 ☐ Yes 2 ☐XNo If Yes, Give 1 ☐ Yes 2 XNo Specify: White 3 ☐ Widowed 4 ☐ Divorced Specify: Year or Dates 15. Decedent's Education 16a Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) Montgomery County Elementary/Seconday (0-12) College (1-4 or 5+) 12 Teacher's Aide Public Schools 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Joseph Rosenberg Esther Molly Ginsberg 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 20904 Frank Roland Greenspan, husband 12509 Summerwood Drive, Silver Spring, Maryland 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date cemetery, crematory or other place) 1 🛮 Burial 2 🗆 Cremation 3 🗀 Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Lebanon Cemetery 12/22/2009 Adelphi, Maryland 21. Signature of Funeral Service Licensee 22 Name and Address of Facility EDWARD SAGEL FUNERAL DIRECTION, INC. MO1255 1091 Rockville Pike, Rockville, Maryland 20852 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between METASTATIC OVARHAN CARCINOMA Immediate Cause (Final Onset and Death disease or condition resulting in death) Due to (or as a consequence of): ARNITUMIA CARDIAT. Due to (or as a consequence of): PLEURAL EFEUSION Due to (or as a consequence of): 19BRILLATION 23c. If yes, outcome of pregnancy 1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ in the past 12 months? Pregnant at time of death Month Year Day Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? HYDESUZENSION 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown MIRLITUS DIABETES Were autopsy findings available prior to completion of cause of 24a. Was an autopsy performed' death? 1 Yes 2 No Yes 2 No 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Inpatient 2 ER/Outpatient 3 DOA

Physician/ Medical Examiner

that the death certificate be executed

68760

Box

P.O.

Records,

of Vital

Division

Hospital or Attending Physician:

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neral Director: Aff

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Physician/

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Director

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Director

"natural", or items 23a or 28a-f show edical Examiner must be notified at

Baltimore, Maryland 21215-0036

permit. Page 1 and 2 should be filed within 72 hours Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natur any injury or other traumatic event, the Medical.

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury that initiated events resulting in death) Last

25. Was case referred to medical 1 ☐ Yes 2 ☑ No

28b. Time of

28c. Injury at

27. Manner of Death 1 Natural

5 Pending 2 Accident
3 Suicide
4 Homicide Investigation 6 Could not be

determined

22

MAAMINI, MD

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

28a. Date of injury (Month, Day, Year)

work 1 ☐ Yes 2 ☐ No

🖵 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29b. Signature and litle of certifier

29d. Date signed (Month, Day, Year)

SHAHO SHAMIM, ND. WASHINGTON ADVETIST HOSP, TAKOMA PARK, MD-20912 31. Date filed (Month, Day, Year)

32. Registrar's Signature recen

State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ 2009 9:20 Eugene Darrell Glover December Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death Examiner 4c. County of Death Ellicott City Ellicott City Health & Rehab Howard Social Security Number If Under 1 Year If Under 24 Hrs. 8 Date of Birth 9. Birthplace (State or Foreign 7. Age (In vrs. last birthday) **Funeral** 1 🗓 M 2 🗆 F Months Days Min. 1270 Py 1922 Arkänsas Director 499-12-7417 87 Usual Residence of Decedent or 28a-f show 10b. County 10a. State Examiner must be notified at 10c, City, Town or Location 10d. Inside City Limits Director 1 X Yes 2 No Maryland Laurel Anne Arundel 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? items 23a Funeral 3517 Piney Woods Place, #E102 20724 U.S.A. 12. Was Decedent Ever in U.S. Armed Forces? 1 ☑ Yes 2 ☐ No If Yes, Give Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, "natural", or <u>8</u> 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify. 3 🗓 Widowed 4 🗆 Divorced Specify: Completed WWII Caucasian Year or Dates injury or other traumatic event, the Medical 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life, DO NOT use retired) permit. Page 1 and 2 should be filed within 72 Department of Health and Mental Hygiene. Important: If item 27 is marked other than ' Machinist Union Elementary/Seconday (0-12) College (1-4 or 5+) Secretary/Treasurer & Aerospace Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ဂ Ernestine Elizabeth Henry Curtis Lee Glover 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Jeanette Louderback - Daughter 8484 Rooster Court. Laurel. Maryland 20723 20b. Place of Disposition (Name of cemetery, crematory or other place, 20a. Method of Disposition Date 20c. Location - City or Town, State 1 Burial 2 Cremation 3 Removal from State Ft. Lincoln Mausoleum 12/22/2009 | Brentwood, Maryland 4 Donation 5 D Other (Specifit Intambrient of Funeral/Service Licensee 22. Name and Address of Facility Hines-Rinaldi Funeral Home. 11800 New Hampshire Ave., Silver Spring, 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final Onset and Death Cardio Vas Cular Athero Scleno lic Physician/ disease or condition Medical resulting in death) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examine Cause (Disease or linjury that initiated events Due to (or as a consequence of): resulting in death) Last Physician/Medical that the death certificate be the attending p for use as t IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ____ in the past 12 months?

1 Yes 2 No Pregnant at time of death signed by the a 9 Unknown Unknown Part II. <mark>Other significant conditions</mark> contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Physician: The law requires 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed certificate has page 2 🗌 No Yes 2 No 1 Yes 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: 2. No Other: 1 🗌 Yes မ 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) this 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at Certificate: 28d. Describe how injury occurred work?
1 Yes 2 No Natural injury 5 Pending Accident Investigation M 3 ☐ Suicide 4 ☐ Homicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Medical

Box 68760 P.O. Records, Division of Vital Hospital or Attending n 24 hours after death.
e Funeral Director: After the function of the function completed filled in by To the I within 2

State

15+1

29a. Certifier

only one)

29b. Signature and title of certifier

Registrar

DHMH 17 Rev 7/2009

31. Date filed (Month, Day, Year)

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Sabapathi

201-109 Back

Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

30641

River Neck Road Baltimore Maybul 2/22

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 2009 42900 Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2 Date of Death Physician/ Month Day 10:27 AM Leona Hilda Gowans 2009 Medical 4a. Facility Name (if not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Death Examiner Hagerstown Washington Washington County Hospital Social Security Number 7. Age (In yrs, last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** Days Hours (Month, Day, Year) August 04, 1926 Country) Maryland Months Director 212-24-2377 Usual Residence of Decedent 28a-f show 10a. State 10b. County traumatic event, the Medical Examiner must be notified at 10c. City. Town or Location 10d. Inside City Limits Director 1 ☐ Yes 2 🗖 No Lonaconing Maryland Allegany 10e, Street and Number 10f. Zip Code ò 10g. Citizen of What Country? Funeral 23a USA 22116 Seldom Seen Road 21539 items 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 11. Marital Status 14. Race - American Indian, Armed Forces? 1 Yes 2 No Black, White, etc. ō ğ 1 Never Married 2 Married 72 hours after Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☐ No Specify: If Yes, Give Year or Dates "natural", Specify. Completed 3 Widowed 4 Divorced White 15, Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) id Mental Hygiene. marked other than Elementary/Seconday (0-12) College (1-4 or 5+) School Teacher 12 Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ည Bessie Green William Green permit. Page 1 and 2 should be Department of Health and Men Important: If item 27 is marke any injury or other traumatic 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Darlene Miller - Daughter 18237 Woodside Drive, Hagerstown, Maryland, 21740 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State December December cemetery, crematory or other place, 1 Burial 2 Cremation 3 Removal from State Lonaconing, Maryland Green Cemetery 4 Donation 5 Other (Specify) 18, 2009 21. Signature of Funeral Service Licenses 22. Name and Address of Facility Eichhorn-McKenzie Funeral Home P.A 8 East Main Street Lonaconing, MD 21539 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ disease or condition resulting in death) Sopre Medical Due to (or as a consequence of): Examiner 2 - - -Azut Coliti Sequentially list conditions. Examine if any, leading to immediate cause. Enter Underlying Due to (or as a consequence of): sician and burial-transit 2.2 death certificate be executed Cause (Disease or linjury that initiated events resulting in death) Last Due to (or as a consequence of): physician the burial Physician/Medical use as IF FEMALE 23c. If yes, outcome of pregnancy 1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 🗆 Ectopic pregnancy atter in the past 12 months? Pregnant at time of death 5 Other (specify) Month Day Year 4 ☐ Pregnant 9 ☐ Unknown 1 Yes 2/1 9 Unknown been signed by the should be detached Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ò Records, 1 Yes 2 No 3 Probably 4 Unknown Completed Schoolie 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an page 2 s autopsy Parkinga Vasalu Derun performed? Hospital or Attending Physician: The certificate 1 Yes 2 No 25. Was case referred to medical funeral director, 26. Place of Death (Check only one) Be examiner? 1 Yes 2 400 Other: 4 Nursing Home 5 Residence 6 Other (Specify) ၉ 1 4 Inpatient 2 ER/Outpatient 3 DOA this 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at Certificate: 28d. Describe how injury occurred After injury 1 Natural 5 Pending work? 1 \(\text{Yes} 2 \) \(\text{No} \) after death. Accident Investigation filled in by the 6 Could not be Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined 24 hours a Funeral I Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. within 24 ho To the Fune completed fi

State Registrar (Check only one)

29b. Signature and title of certifier

VASANT

31. Date filed (Month, Day, Year)

put mo

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

32 Registrar's Signature

340

Box 68760

P.O.

Division of Vital

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

D 18019

29d. Date signed (Month, Day, Year)

2009

21740

DEL 16.

HACERSTOWN, MD

29c. License number

MILL ST

Amended item #1 per Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. physician, 12/28/09; CM State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day **Physician** 12:55AM Helen Merrill Heurick Heurich Dec. 2009 20, /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City. Town, or Location of Death Examiner Accident

If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth (Month, Day, Year) Cherry Hill
5. Social Security Number Assisted Living Garrett Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) **Funeral** 1 □ M 2 💢 F **Director** 1/9/1925 California 528-28-4537 Usual Residence of Decedent 10b. County 10a. State 10c. City, Town or Location 10d. Inside City Limits ed other than "natural", or items 23a or 28a-f show event, the Medical Examinar must be notified at Director 1 ☐Yes 2√☐No MD Garrett Grantsville 10g. Citizen of What Country? 10e. Street and Number Funeral 318 Fairview Road 21536 U.S.A. death 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 11. Marital Status filed within 72 hours after 1 ☐ Never Married 2 ☐ Married Saltimore, Maryland 21215-0036 1 ☐ Yes 2√2 No Completed by If Yes, Give Year or Dates Specify: White 3 ☑ Widowed 4 ☐ Divorced 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) al Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) Executive Secretary Sen. Barry Goldwater 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Pages 1 and 2 should be nent of Health and Mental and Menta S. Merrill Millie Rae Plowman ဂ္ Rulon 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Department of Health Important; If item 27 I other 1 Cynthia Smith/ Daughter 308 Fairview RD., Grantsville, MD 21536 20c. Location - City or Town, State 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Injury or 1 ☐ Burial 2 又 Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Countryside Crem. 12/22/09 Davidsville, PA 22. Name and Address of Facility
Newman Funeral Homes P.A. 21. Signature of Fuheral Service Licens any Ir St., Grantsville, 21536 79 Miller 23a. Part 1. Enter the disease, or complications that caused the eath. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** disease or condition resulting in death) Due to (or as a consequence of) /Medical Examiner Sequentially list conditions, if any, leading to immediate cause in a Union hing Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examine death certificate be executed attending physician and for use as the burial-transit Due to (or as a consequence of): Box 68760. Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☑ No Month 5 Other (specify) P.0. detached 9 Hlinknown been signed by should be detach Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tohacco use contribute to the cause of death? Division of Vital Records, ģ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☑ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an has autopsy performed 1 □Yes 2 □No Hospital or Attending Physician: 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 2 **N**o ၉ 1 ☐ Yes 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA After this funeral 27. Manner of Death 1 Natural 28a. Date of Injury (Month, Day, Year) 28b. Time of Injury 28c. Injury at Work? Certification: 28d. Describe how injury occurred 5 Pending death. 1 ☐ Yes 2 ☐ No investigation 2 Accident within 24 hours after death To the Funeral Director: filled in by the 3 ☐ Suicide 6 Could not be determined 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the course of 29a. Certifier Medical kaminer: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only To the 29d. Date signed (Month, Day, Year) 29b. Signature and tit Af cer 29c. License number D47925 12/21/09 30. Name and address of person the completed cause of death (Item 23a) (Type, Print) Fourth St., Oakland, MD 21550 Charles Walch M.D 311 N. 32. Registrar's Signature State Registrar

DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Day 21, **Physician** 2009 Helen Ovando Hoggarth December 3:30 a M /Medical 4a. Facility Name (If not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death Prince George's Renaissance Gardens at Riderwood Village Silver Spring | If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth (Month, Pay, Year) | 925 5. Social Security Number 6. Sex 7. Age (In vrs. last birthday) 9. Birthplace (State or Foreign **Funeral** New Hampshire 1 M 2 F 003-12-4286 84 Director Usual Residence of Decedent permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the IMACGI Exprired must be notified at once. 10a. State 10b. County 10c, City, Town or Location 10d. Inside City Limits Director 1 ☐ Yes 2 ☐ No Maryland Silver Spring Prince George's 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 3148 Gracefield Road, Apt. 607 20904 USA Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2000No 11. Marital Status Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 ☐ Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 If Yes, Give Year or Dates: 1⊠Yes 2□No Specify: Mexican White ģ Specify: 3 Widowed 4 □ Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Office Manager Financial Services 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Roman O. Ovando Alice Marie Fischer ပ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 911 Notley Road, Silver Spring, MD 20904 Robert L. Hoggarth/Son 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 1 ☐ Burial 2 ② Cremation 3 ☐ Removal from State Dec. Metropolitan Crematory 4 ☐ Donation 5 ☐ Other (Specify) 2009 Alexandria, Virginia 22. Name and Address of Facility.
Francis J. Collins Funeral Home Inc.
FOO University Blvd. W., Silver Spring, MD 20901 21. Signature of Funeral Service Licensee 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** Hepatocellular /Medical Due to (or as a consequence of): **Examiner** Sequentially list conditions, if any loading to in module cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to (or as a consequence of) Hospital or Attending Physician: The law requires that the death certificate be executed burial-tran Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, attending physician for use as the buria Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 - Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Year Day 5 Other (specify) ed by the a 9 Unknown signed I Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 9 cardiac arrhythmia icate has been sig , page 2 should b 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed 24a. Was an 24b. Were autopsy findings available prior to completion of cause of death? autopsy heart disease hypertensive perform this certificate 2 No 1 □Yes 1 ☐ Yes 2 ☐ No director, Be 25. Was case referred to medical 26. Place of Death (Check only one) Other:

Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 1 Yes 2 No Certification: To 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA funeral 27. Manner of Death 28a. Date of Injury 28b. Time of After 1 28c. Injury at Work? 28d. Describe how injury occurred (Month, Day, Year) **1**✓ Natural 5 Pending investigation 2 Accident 1 ☐ Yes 2 ☐ No 6 ☐ Could not be 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 ☐ Homicide 12 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier (Check only one)

Registrar

29b. Signature and title of certifier

31. Date filed (Month, Day, Year)

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2. Registrar's Signature

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

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29c. License number

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Deged nt's Name (First, Middle, Last) 2. Date of Death Physician/ Month, Year acksor Medical 4b. City, Town, or Location of Death

86000LDGEO

BETHESA MD 4a. Facility Name (if not institution, give street and number, Examiner 4c. County of Death geTbwnR 70 ONTGOMERI 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign Country) **Funeral** (Month, 1 M 2 F Months Days Hours Min. Day Director Usual Residence of Decedent permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any Injury or other traumatic event, the Medical Examiner must be notified at 10a, State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director LONTOOM ERU 1 Yes 2 □ No omac 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 854 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Armed Forces? Black, White, etc 1 Never Married 2 Married þ Baltimore, Maryland 21215-0036 Specify AFRICIAN AMERICAN If Yes, Give Year or Dates 1 Yes 2 No Specify: 3 Divorced 4 Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) GOUT. Elementary/Seconday (0-12) College (1-4 or 5+) AU NAU Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ပ ac 19a. Informant's Name/Relationship (Type, Print) doughter 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) d IANDWOOD LANHAN 20a. Method of Disposition 20b. Place of Disposition (Name of Location - City or Town, State 1 Burial 2 Cremation 3 Removal from State cemetery, crematory 23.09 4 Donation 5 Other (Specify) 21. Signatuw Funeral Service Lice 22. Name and Address of Facility STATE FUNERAL Services M00943 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Immediate Cause (Final Onset and Death Physician/ disease or condition Medical resulting in death) Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examine Due to (or as a consequence of): To the Hospital or Attending Physician: The law requires that the death certificate be executed Cause (Disease or illingly that initiated events resulting in death) Last attending physician and for use as the burial-trans Due to (or as a consequence of): Physician/Medical 68760 IF FEMALE: 23c. If yes, outcome of pregnancy

1 Live Birth 2 Fetal death
4 Pregnant at time of death
9 Unknown 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregna 5 ☐ Other (specify) P.O. Box Ectopic pregnancy in the past 12 months?
1 ☐ Yes 2 ☐ No s been signed by t should be detach Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by Division of Vital Records, 1 ☐ Yes 2 🗶 No 3 ☐ Probably 4 ☐ Unknown . Were autopsy findings available prior to completion of cause of death? 24a. Was an page 2 s autopsy performed? Yes 2 2 No After this certificate 1 Yes 2 No 25. Was case referred to medical Certificate: To Be 26. Place of Death (Check only one) examiner? 2 X No Other: 1 X Inpatient 2 🗆 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify, 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of injury 28c. Injury at 28d. Describe how injury occurred 1 Natural 2 Accident 5 Pending within 24 hours after death.

To the Funeral Director: A completed filled in by the fu 1 Yes 2 No Investigation 6 Could not be 3 ☐ Suicide 4 ☐ Homicide Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, determined City or Town, State) Medical 1 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier (Check Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29b. Signature and title 042578 Dec. 16, 2009 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Chablan Suite 401 - ROCKVIlle, Md. 20852

State Registrar 31. Date filed (Month, Day, Year)

DEC 22

2009

acilisa

State of Maryland / Department of Health and Mental Hygiene O 9

Certificate of Death Reg. No. 1 - For State Registrar

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Silver Spring MD 20904

Physicia /Medica Examine

Funeral Director

Baltimore, Maryland 21215-0036

hysician /Medical **Examiner**

Division of Vital Records, P.O. Box 68760,

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any Injury or other traumatic event, It at Medical Exeminer must be notified any once. To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

	Tiegistrai									cg			
	1. Decedent's Name (First, Middle, Las	t)							2. Date of D Month		Day	Year	3. Time of Death
i		Leonard		.h	,				Decem			2009	11:05 рм
r	4a. Facility Name (If not institution, give				4b. City,		Location					y of Death	
	Renaissance Garde				If Unde		Ver :				Prin		orge's
	5. Social Security Number 6. Se	ex MZM2□F	'. Age (In yrs.	"	Months	Days	Hours	Min.	8. Date of E (Month, L	Day, Yea		9. Birth	
	Usual Residence of Decedent		87	, ,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,		L			02/26	/192	22		New York
	10a. State 10b. County		10c. Cit	ty, Town or Lo	cation		_				10d. Inside City Limits		
ō	Maryland Philipp C	en to all				c:	0	Cost	í ia c				1 □Yes 2 📉 No
rec:	Maryland Prince G 10e. Street and Number	eorge's			10f. Zit		lver	Spru	cng	10a. (Citizen of	What Cou	ntrv?
by Funeral Director	3156 Gracefield F	and #1	15				209	0.4				u.s.	
era	11. Marital Status	12. Was Deced		S 13 1	Was Dece	dent of H			ecify Ves or N	lo-	14 Ra		can Indian,
ב	1 Never Married 2 Married	Armed Ford	es?	17			n, Mexicai	n, Puerto	ecify Yes or N Rican, etc.)			ack, White,	
	3 ☐ Widowed 4 ☐ Divorced	1 ⊠Yes 2 If Yes, Give Year or Dai	tes: 194	_	1 □ Yes	2 💆 No	Specify:	•			Speci	ity:	Caucasian
Completed	15. Decedent's Edi	ucation		16a. Dece						16b.	Kind of E	Business/In	
De	(Specify only highest grad	de completed) College (1-4	10r E .)	(Give	kind of wo DO NOT u	ork done d se retired	during mos l)	t of work	ing	Ŧ			
E	Liementary/Getoridary (0-12)	4	+01 3+)	Т Т	extil	le Ex	cecut	ive				Texti	le
a	17. Father's Name (First, Middle, Last)						18. Moth	er's Nam	e (First, Middi	le, Maid	en Surna	me)	
0	Joseph	i Koch						(Celia (veis	s		
	19a. Informant's Name/Relationship (7	ype. Print)		19b. Mailir	ng Address	s (Street	and Numb	er or Rur	ral Route Num	ber, Cit	y or Towr	n, State, Zij	Code)
	Barbara Koch - S	Spouse		3156	Grace	efiel	d Rd	#4	15. Si	lver	. Spr	ing.	MD 20904
	20a. Method of Disposition		20b. F	Unner of Direct	-iti (Alo	ma af			Date			- City or To	
	1 🖾 Burial 2 ☐ Cremation 3 🖾 4 ☐ Donation 5 ☐ Other (Specify		tate Ki	remetery, crem 19 Solo 2morial	mon	h		12/2	2/2009	ري ا	1150	un Ma	ow Tonkou
	21. Signature of Funeral Service Licens	see		22	2. Name a	nd Addre	ss of Facili	ty train	aus-Ris	nald	i. Fu	neral	w Jersey Home, Inc.
	Chr Kow	e M	0//00										g, MD 20904
	23a. Part 1. Enter the disease, or comp shock, or heart failure. List only of	lications that ca	used the deat										Approximate Interval Between
	Immediate Cause (Final disease or condition		bral V	asoula	# 100	iday	, +						Onset and Death
	resulting in death)	u.	r as a conseq		ACC	nuer	и						
		ь Соло	nary A	ntonu	Dixoc	150							
ner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury		as a conseq										
Ē	that initiated events	c. Atri	al Fib	rillat	ion								
ЕX	resulting in death) Last	Due to (o	r as a conseq	uence of):									
Medical		d											
Med	IF FEMALE:									-		=	
any	23b. Was decedent pregnant	23c. If yes, outco	ome of pregna rth 2 ☐ Feta		Tectopic r	oregnanc	/					ate of deliv	
nysici	in the past 12 months? 1 ☐ Yes 2 ☐ No		ant at time of c		Other (s						M	lonth	Day Year
, I	9 Unknown								17				
D.	Part II. Other significant conditions co	ontributing to dea	th but not resi	ulting in the ur	nderlying o	ause give	en in Part I	•					he cause of death?
ed	Gout						<u> </u>		1] Yes	2 No	3 X Pro	bably 4 🗌 Unknown
completed by	Polymyalgia Rhe	rumatica			24a. Was an autopsy prior to completion o						opsy findings available		
E	Benign_Prostate			,	performed? death?								
D)	25. Was case referred to medical	ce ngper	<i>xcoping</i>		1 □ Yes 2 □ No 1 □ Yes 2 □ No 26. Place of Death (Check only one)								
0	examiner? 1 ☐ Yes 2 🛣 No	Hospital: 1 ☐ In	patient 2 🗌	ER/Outpatier	nt 3 🗆 D0	OA Othe	er: 4 🔯 Ni	ursing Ho	me 5 ☐ Re	sidence	6 🗆 Ot	ther (Speci	fy)
: I	27. Manner of Death 1 X Natural 5 ☐ Pending	28a. Date of (Month	Injury , <i>Day, Year</i>)	28b. Time of Injury	f 2	28c. Injur Worl			28d. Describe				
a	2 ☐ Accident investigation				М		Yes 2□	No					
	3 ☐ Suicide 6 ☐ Could not be 4 ☐ Homicide determined	28e. Place o	f Injury - At ho g, etc. <i>(Specif</i>	ome, farm, str	eet, factor	y, office			28f. Location City or To	(Street	and Num	ber or Rur	al Route Number,
Certification:										, -/-	,		<u> </u>
Medical	29a. Certifier 1 (X) Certifying Phy (Check only one) 2 ☐ Medical Exam	iner: On the bas	sis of examina	wledge, death tion and/or in	h occurred vestigation	at the tir	ne, date a pinion, dea	nd place, ath occur	and due to the red at the time	ne cause e, date a	e(s) and n and place	manner as , and due t	stated. o the cause(s)
one) and manner stated. 29b. Signature and title of certifier 29c. License number						umber 29d. Date signed (Month, Day, Year)							
29b. Signature and title of certifier						29d. Date signed (<i>World</i>), <i>Day</i> , <i>Tear</i>)							

Registrar DHMH 17 Rev 1/2001

State

3110

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

€2. Registrar's Signature

31. Date filed (Month, Day, Year)

DEC 22

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ David Edward Kazdan December 2009 9:43 Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death Holy Cross Hospital Silver Spring Montgomery Social Security Number If Under 1 Year If Under 24 Hrs. 7. Age (In vrs. last birthday) 8 Date of Birth **Funeral** 9. Birthplace (State or Foreign 1 X M 2 - F Days Hours Min 0 1/28 7 947 Michigan **Director** 68 Yrs 375-38-5056 Usual Residence of Decedent ems 23a or 28a-f shov r must be notified at CR 10a State 10c. City, Town or Location 10d. Inside City Limits Director 1 X Yes 2 No MD Montgomery Silver Spring 10e Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 12830 Lacy Drive 20904 USA 12. Was Decedent Ever in U.S. Armed Forces?
1 ☐ Yes 2 ☒ No If Yes, Give 11. Marital Status 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. Medical Examiner Black, White, etc. ģ 1 Never Married 2 Married Maryland 21215-0036 1 ☐ Yes 2 X No Specify. White "natural", Completed 3 Widowed 4 Divorced Year or Dates 15. Decedent's Education 16a Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life, DO NOT use retired) al Hygiene. Elementary/Seconday (0-12) College (1-4 or 5+) the 5+ Certified Public Accountant Private Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) and Mental F ၉ Morris Kazdan Anne Rechtman 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1 and 2 s of Health a item 27 i Barbara Kazdan, wife 12830 Lacy Drive, Silver Spring, Maryland 20904 Baltimore, 20a Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Page 1 a Date Important: If it any injury or o cemetery, crematory or other place) 1 Durial 2 Cremation 3 Removal from State 4 ☐ Donation 5 ☐ Other (Specify) National Crematorium 12/23/2009 Falls Church, Virginia Signature of Funeral Service Licensee 22 Name and Address of Facility EDWARD SAGEL FUNERAL DIRECTION, INC. Mohit MO1255 1091 Rockville Pike, Rockville, Maryland 20852 23a. Parti. Enter the the ease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final Onset and Death Physician/ disease or condition resulting in death) Myocardial Infarction ر Medical Examiner Due to (or as a consequence of) Coronary Artery Disease Sequentially list readitions if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Due to (or as a consequence of) Exami that initiated events resulting in death) Last Due to (or as a consequence of): attending physician for use as the buria Physician/Medical IF FEMALE 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death
4 Pregnant at time of death
9 Unknown 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ in the past 12 months? Dav Year Yes 2 No 9 Unknown þ Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Atrial Fibrillation 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? Cerebrovascular Disease 24a Was an performed? Yes 2 X No Hyperlipidemia 2 🗌 No 1 Tyes 25. Was case referred to medical Be 26. Place of Death (Check only one) Hospital 1 ☐ Yes 2 ☐XNo Other: ည 1 ☐ Inpatient 2 🖾 ER/Outpatient 3 ☐ DOA 4 Nursing Home 5 Residence 6 Other (Specify) 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at Certificate: 28d. Describe how injury occurred 1 X Natural 5 Pending work? 1 ☐ Yes 2 ☐ No Accident injury Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined

68760 Box P.O. Records, Vital of Hospital or Attending Division nours after death.

neral Director; Aft

filled in by the fur الم 24 hours. o the Funeral Decompleted filler.

> State Registrar

DHMH 17 Rev 7/2009

Medical

29a. Certifier

(Check

Signature and title of ce

31. Date filed (Month, Day, Year,

DEC 22

erson who completed cause of death (Item 23a) (Type, Print)

Oertifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated

Dr. David Edward Rogers, 5530 Wisconsin Ave, Suite 1400, Chevy Chase, MD 20815

29c. License number D50030

vical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated

December 17, 2009

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Qn 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ December 14, 2009 Albert David Levy 5:31 PM Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death Holy Cross Hospital Silver Spring Montgomery 5. Social Security Number **Funeral** 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign 1 ፟ M 2 □ F Months Days Hours Min. 05/28/1941 Director 577-62-3747 68 Egypt Usual Residence of Decedent 3a or 28a-f show t be notified at 10b. County 10c. City, Town or Location Director 10d. Inside City Limits within 72 hours after death with the Man 1 X Yes 2 □ No MD Montgomery Silver Spring 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 23a Funeral **Examiner must** 12722 Teaberry Road 20906 United States 12. Was Decedent Ever in U.S. 11. Marital Status Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Armed Forces?
1 ☐ Yes 2 🛣 No 10 ğ 1 Never Married 2 Married Maryland 21215-0036 1 ☐ Yes 2 🛣 No Specify. Specify: White 3 X Widowed 4 Divorced Completed Year or Dates permit. Page 1 and 2 should be filed within 72 hour Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natur any injury or other traumatic event, the Medical 15. Decedent's Education 16a, Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) 5+ Accountant Private/Gen. Electric Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ည David Levy Rachel Bokey 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Joseph Levi/brother 12722 Teaberry Road Silver Spring, MD 20906 Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date 🗷 Burial 2 🗆 Cremation 3 🗆 Removal from State cemetery, crematory or other place) 4 ☐ Donation 5 ☐ Other (Specify) Mt. Lebanon Cemetery 12/22/2009 Adelphi, MD 21. Signature of Funeral Pervice License Ed 22. Name and Address of Facility
Danzansky-Goldberg Memorial
1170 Rockville Pike Rockville, MD 208 M00910 Edward Sage1 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate shock, or heart failure. List only one cause on each line Interval Between Onset and Death Immediate Cause (Final Physician/ disease or condition resulting in death) Cerebrovascular Accident Medical Due to (or as a consequence of): ²Examiner Sepsis Sequentially list conditions, it any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury that initiated events resulting in death) Last Examiner Due to (or as a consequence of) been signed by the attending physician and should be detached for use as the burial-transit Hyperkalemia Due to (or as a consequence of): Physician/Medical To the Hospital or Attending Physician: The law requires that the death certificate bewithin 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physicia Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? Day 5 Other (specify) Month Year 2 No 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 🔀 Unknown 24b. Were autopsy findings available prior to completion of cause of death? performed? Yes 2 K No 25. Was case referred to medical æ 26. Place of Death (Check only one) examiner? 1 X Yes Hospital: 2 No ၉ Other: 1 Inpatient 2 X ER/Outpatient 3 IDOA Director: After this din by the funeral dir 4 Nursing Home 5 Residence 6 Other (Specify) 28a. Date of injury (Month, Day, Year) Certificate: 27. Manner of Death 28b. Time of 28c. Injury at 28d. Describe how injury occurred X Natural 5 - Pending 1 Yes 2 No ☐ Accident Investigation 3 ☐ Suicide 4 ☐ Homicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) filled in by 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certifie 29c. License number 29d. Date signed (Month, Day, Year) D0067355 December 14, 2009

State Registrar Silver Spring, MD 20910

1500 Forrest Glen Road

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Daniel Sherk

DEC 22

31. Date filed (Month, Day, Year

Registrar DHMH 17 Rev 1/2001

State

P.O. Box 68760.

Records.

Please Type or Print in Black Indelible Ink Ensure All Copies Are Legible.
State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death Reg. No 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death . 2<u>009</u> Physician/ Month DEC. WARREN JAMES LUKE 9:50A Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner CHARLOTTE HALL VETERANS HOME CHARLOTTE HALL ST.MARY'S If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign MAY 13, Year 924 NEW YORK Months Days Hours Min 85 Director 032-16-7897 Usual Residence of Decedent or than "natural", or items 23a or 28a-f show the Medical Examiner must be notified at 10a. State 10c. City, Town or Location 10d. Inside City Limits Director ST. MARY'S MD. CHARLOTTE HALL 1 Yes 2 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 29449 CHARLOTTE HALL RD. 20622 U.S.A. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14. Race - American Indian, Armed Forces?

1 Y Yes 2 No ARMY
If Yes, Give
Year or Dates. WWII Black, White, etc. þ 1 Never Married 2 X Married Maryland 21215-0036 1 Yes 2 No Specify: Specify: WHITE 3 Widowed 4 Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) should be filed with and Mental Hygien is is marked other ti D.C.GOVT. SOCIAL WORKER Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ၉ JAMES THEODORE LUKE ETTA AUSTIN 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Page 1 and 2 sh Dej artment of Health ai Important; If item 27 is any injury or other trau BETTY LUKE-SPOUSE 5173 COLEBROOK DR. LA PLATA, MD. 20646 Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State 1 ☐ Burial 2X Cremation 3 ☐ Removal from State METROPOLITAN CREMATORY 12-29-09ALEX., VA. 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility
RAYMOND FUNERAL SERVICE, P.A.
LA PLATA, MD. 20646 21. Signature of Funeral Service Licensee M00479 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ -ZHEI disease or condition resulting in death) Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Examine Due to (or as a consequence of) ed by the attending physician and detached for use as the burial-transit that initiated events resulting in death) Last Due to (or as a consequence of) Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?
1 ☐ Yes 2 ☐ No Month 5 Other (specify) Day Year Pregnant at time of death Unknown 9 🔲 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by PARKINSONS DISEASE 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown MELLITUS DIABETUS 24b. Were autopsy findings available prior to completion of cause of death? performed 1 Yes 2 No 25. Was case referred to medical æ 26. Place of Death (Check only one) examiner? Hospital 1 ☐ Yes 2 ☐ No Other: |၉ 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify, 28a. Date of injury (Month, Day, Year) 27. Manner of Death Certificate: 28b. Time of 28c. Injury at work? 28d. Describe how injury occurred 1 Natural 5 Pending within 24 hours after death.

To the Funeral Director: A completed filled in by the fu 1 Yes 2 No ☐ Accident Investigation 3 Suicide
4 Homicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined e Funeral E Medical 1 🖵 🌀 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 3 🗌 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated within 2 only one) 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) D67788 12.28.2009 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) EENA RAO KODALI Calvert Family Care 14090 HG Trueman Rd. Ste. 2300 Solomon, Md. 31. Date filed (Month, Day, Year State JAN 1 1 2010 Registrar

DHMH 17 Rev 7/2009

Registrar

AMENDED BY COURT ORDER Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

AMEND#19a percourt order. G979 9/13/2016 WS
State of Manyland Department of Health and Mental Hygiene 1 - For State Registrat Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month Year Physician Vanderlei Dalla Costa Marques 4:10 A M December 15, 2009 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner 7609 Fontaine Street Potomac Montgomery If Under 1 Year If Under 24 Hrs. 8. Date of Birth Months Days Hours Min. (Month, Day, Year) 5. Social Security Number 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** 1**∑**M 2□ F 215-11-7439 Director 66 June 3, 1943 Brazil Usual Residence of Decedent with the Maryland 10a. State 10c. City, Town or Location 10b. Count 10d. Inside City Limits r than "naturel", or items 23a or 28a-f show the Medical Examiner must be notified at 1 ☐ Yes 2 No Directo Montgomery Potomac 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 7609 Fontaine Street 20854 Brazil filed within 72 hours after death Funeral 12. Was Decedent Ever in U.S. Armed Forces? Race - American Indian, Black, White, etc. 11. Marital Status Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 Yes 2 No If Yes, Give Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify: Specify: White by 3 ☐ Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry other than College (1-4or 5+) 5+ Elementary/Secondary (0-12) Loan Officer International Org. 17. Father's Name (First, Middle, Last) permit. Peges 1 and 2 should be life Depertment of Health and Mental Hy Important: if Item 27 is marked oth any lighty or other treumatic event ADR. 18. Mother's Name (First, Middle, Maiden Sumame) Oswaldo Marques Adiles Dalla Costa 19a. Informant's Name/Relationship (*Type, Prigt*)
19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Z
Elaine Pereira Jones Marques/wife 7609 Fontaine Street Potomac, MD 20854 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 ☐ Burial 2 XCremation 3 ☐ Removal from State Final Journey Crematory 12/19/09 Woodbine, MD 4 □ Donation 5 □ Other (Specify) 21. Signature of Funeral Service Licensee Going Home Cremation Service P.O. Box 784 MD 21029 MO1251Beverly L. Heckrotte, P.A. Clarksville, 23a. Part1. Enter the distrase, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** Lung Cancer /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any loading to intra-class cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner The law requires that the death certificate be executed attending physicien and for use as the burial-transit Due to (or as a consequence of) Division of Vital Records, P.O. Box 68760 ician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal de. 23d. Date of delivery 23b. Was decedent pregnant 2 ☐ Fetal death 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day 4 Pregnant at time of death 5 Other (specify) detached Physic 9 Unknown been signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 🖾 Yes 2 🗆 No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has autopsy performed? Yes 2X No 1 ☐ Yes 2 ☐ No 1 ☐ Yes To the Hospitel or Attending Physician: Be 25. Was case referred to medical 26. Place of Death | Check only one examiner' Other: 4 Nursing Home 5 AResidence 6 Other (Specify) Hospital: 1 ☐ Yes 2 🔀 No 1 Inpatient ၉ 2 ER/Outpatient 3□ DOA this 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred After Certification: 1 XNatural 5 Pending Injury М 1 Tes 2 No 2 Accident investigation the 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 - Homicide To the Funerel 1 Certifying Physician: To the best of my knowledge death occurred at the time date and place, and due to the date o(e) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Medicai 29a. Certifie (Chack only one) 29b. Signature and title of certifie 29c. License number 29d. Date signed (Month, Day, Year) D65214 December 16, 2009 30. Name and address of person who completed cause of death (ftem 23a) (Type, Print) 10 Lisa Houde McGrail, M.D. 5454 Wisconsin Ave. #1300 Chevy Chase, MD 20815

Registrar

DHMH 17 Rev 1/2001

State

31. Date filed (Month, Day, Year)
DEC 1 8 2009

Warted

32. Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene for State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Month Mentzer 2009 Evelyn Jane December 9:40 P Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death Broadmore Assisted Living Hagerstown Washington Social Security Number If Under 1 Year If Under 24 Hrs. 9. Birthplace (State or Foreign 7. Age (In yrs. last birthday, 8. Date of Birth Funeral (Month, Day, Hours ^{Year)} 18 Days Maryland Director 214-09-5834 Oct. Usual Residence of Decedent 10a. State 10b. County item 27 is marked other than "natural", or items 23a or 28a-f sho other traumatic event, the Medical Examiner must be notified at 10c. City. Town or Location 10d. Inside City Limits Director 1 XYes 2 □ No Maryland Washington Hagerstown 10e, Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral with 1 437 Clarendon Ave. 21740 U.S.A. within 72 hours after death 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 11. Marital Status 14. Race - American Indian Armed Forces? Black, White, etc. þ 1 Never Married 2 Married Baltimore, Maryland 21215-0036 If Yes, Give Year or Dates 1 Yes 2 No Specify: Specify: 3 Widowed 4 Divorced Completed White 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) should be filed within 72 In and Mental Hygiene.
7 Is marked other than "r Elementary/Seconday (0-12) College (1-4 or 5+) q Homemaker Domestic Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ည Amos Lynn Ima Nalley Na 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1 and 2 s of Health item 27 Bryan / Daughter Hykes Rd. Greencastle, Pennsylvania 17225 2097 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place, 20c. Location - City or Town, State Date Page 1 ō<u>∓</u> Department of Important: If it any injury or o 1 Burial 2 Cremation 3 Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 12/31/2009 Hagerstown, Maryland Rest Haven Cemetery 21. Sign of Funeral Service Licen 22. Name and Address of Facility Rest Haven Funeral Chapel 1601 Pennsylvania Ave. Hagerstown, Maryland 21742 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest. Approximate Interval Between On t and Death shock, or heart failure. List only one cause on each line Immediate Cause (Final Physician/ disease or condition resulting in death) Medical Due to (Mas a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury that initiated events consequence of or as a Exami Hospital or Attending Physician: The law requires that the death certificate be executed attending physician and for use as the burial-tran resulting in death) Last Due to (or as a consequence of): Physician/Medical Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery ☐ Ectopic pregnancy in the past 12 months? 5 Other (specify) Month Day Year Pregnant at time of death ed by the a detached t 9 Unknown 9 Unknown Division of Vital Records, P.O. signed by t Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 Tes 2 No 3 Probably 4 Unknown peen 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has autopsy perform certificate 1 ☐ Yes 2 ☐ No 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 Residence 6 H Other (Specify) 2 1 No ဂ္ 1 Inpatient 2 ER/Outpatient 3 DOA this 27. Manner of Death 28a. Date of injury (Month, Day, Year) Certificate: 28b. Time of within 24 hours after death.

To the Funeral Director: After I completed filled in by the funera 28c. Injury at 28d. Describe how injury occurred 5 Pending 1 🛱 Natural 1 🗌 Yes 2 🗌 No Accident Investigation 3 ☐ Suicide 4 ☐ Homicide 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) Location (Street and Number or Rural Route Number, City or Town, State) determined Medical 1 🗜 ertifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Cartifying Nurse Practioner: To the basis of my included a death occurred at the time, date and place, and due to the cause(s) and manner stated Cartifying Nurse Practioner: To the basis of my included a death occurred at the time, date and place, and due to the cause(s) and manner as each of the cause(s) and manner as each of the cause (s) and manner as each of 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year)

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Registrar

Muhammad

31. Date filed (Month, Day, Yea

AAN 1 1 2010

Ct

Hagerstown, Maryland 21740

1126 Opal

32. Registra

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Waseem.

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

AMEND ITEM#30perDVR,G899,1/11/2010,WS

State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death ^{Day}22, MacDouga11 **Physician** Charlotte 2009 Arlene December 6:30 PM /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** Washington Ravenwood Lutheran Village Hagerstown If Under 1 Year | If Under 24 Hrs. Months | Days | Hours | Min. 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) Social Security Number 6. Sex **Funeral** Days 1 □ M 2 □ F 042-12-3816 87 Director June 26, 1922 Connecticut Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 10a. State 10b. County 28a-f show permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryla Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any Injury or other traumatic event, If a Modical Examinet must be redifficed at once. 1√ Yes 2 No Directo Maryland Washington *Hagerstown* 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 202 South Prospect St. 21740 USA Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 14. Race - American Indian, 11. Marital Status Black, White, etc. Navy 1 X Yes 2 ☐ If Yes, Give Year or Dates: 1 ☐ Never Married 2 ☐ Married 3altimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify: WWII Specify: White þ 3 ☑ Widowed 4 ☐ Divorced Be Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Business Executive Boating 1 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Gilbert E. Wishart Olive I. Gates မှ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) Dan Kennedy (Son) 202 S. Prospect St. Hagerstown, Maryland 21740 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition December 1 ☐ Burial 2 【 Cremation 3 ☐ Removal from State Smithsburg, Maryland Smithsburg Crematory 24, 2009 4 Donation 5 ☐ Other (Specify) 22. Name and Address of Facility Signature of Funeral Service Licensee J.L. Davis Funeral Home MO1414 Jegg 12525 Bradbury Ave. Smithsburg, Maryland 21783 Lee AUIS Approximate Interval Between Onset and Death 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) 24 has **Physician** nemonua /Medical Due to (or as a consequence of): Examiner Years emen Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner Hospital or Attending Physician: The law requires that the death certificate be executed 24 hours after death.
Funeral Director: After this certificate has been signed by the attending physician and burial-transit P.O. Box 68760. Due to (or as a consequence of): Physician/Medical the. IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 4 ☐ Pregnant at time of death 5 ☐ Other (specify) nis certificate has been signed by the director, page 2 should be detached 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, þ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☑ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autonsy performed? Yes 2 No 2 🗆 No 1 ☐ Yes 1 ☐ Yes Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: Other: 447 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 ₩o 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To completely filled in by the funeral 27, Manner of Death 28b. Time of Injury 28a. Date of Injury (Month, Day, Year) 28d. Describe how injury occurred Natural 2 Accident 5 Pending investigation 1 ☐ Yes 2 ☐ No 6 ☐ Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 ☐ Homicide e Funeral I TX Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

I Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) Medical 29a. Certifier (Check only one) and manner stated. To the within 2 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 028365 23/09 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

DHMH 17 Rev 1/2001

10

State Registrar Monzar J. Shafi

31. Date filed (Month, Day, Year)

368 Mill St. Hagerstown, Md. 21740

Antietam Geriatric & Internal Med.

32. Registrar's Signature

09-09718 Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Chang Tien Mou 2009 42913 1- For State Certificate of Death Registrar 2. Date of Death Decedent's Name (First, Middle,Last) Physician/ Month Day December 14, 2009 Chang Tien Mou 1016 hrs **Medical Examiner** 4c. County of Death 4a. Facility Name (if not institution, give street and number) 4b. City. Town, or Location of Death Howard Howard County General Hospital Columbia 5. Social Security Number If Under 1 Year If Under 24Hrs. 8. Date of Birth/MM/DD/YYYY 9. Birthplace (State or 7. Age (In yrs. last birthday) **Funeral** Min Months Director Davs Hours 214-43-8686 Country) Taiwan 12/1/1949 1 M 2 F 60 Usual Residence of Decedent 10d. Inside City Limits 10a State 10b. Count 10c. City, Town or Location 1 Yes 2 X No or 28a-f show 23a or 28a-f shonotified at one. Howard Columbia MD more, MD 21215-0036
Pages I and 2 should be filed within 72 hours after death with the Maryland nen of Health and Mental Hygiene. Director 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country 6030 Shepherd Square 21044 USA Funeral 14. Race - American Indian, Black, 11. Marital Status 12. Was Decedent Ever in U.S Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) ä White etc. Armed Forces? must 1 Never Married 2 Married Yes Specify: Asian If Yes. Give Year Yes 2 X No specify: 3 Widowed Divorced ant: If item 27 is marked other than "natural", or other traumatic event, the Medical Examiner \$ 16a. Decedent's Usual Occupation (Give kind of work done 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Completed during most of working life. DO NOT use retired) College (1-4 or 5+) Elementary/Secondary (0-12) Clerk Federal 18.Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Hsiu Ying Lu Chih Che Mou 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 10333 Breconshire Rd., Ellicott City, MD 21042 Mei Chu Lin / Wife 20c. Location - City or Town, State Baltimore, I permit. Pages I and 20a, Method of Disposition crematory or other place) Department of I Burial 2 Cremation 3 Removal from State 12/17/2009 Ardent Cremation Hanover, MD Donation 5 Other Sp 22 Name and Address of Facility Harry H. Witzke's Family FH, Inc. 21. Signature of Funeral Service M01411 4112 Old Columbia Pike, Ellicott City Approximate Interval 23a. Part II. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or hear **Physician** Between Onset and /Medical Death a Hypertensive Atherosclerotic Cardiovascular Disease Immediate Cause (Final disease Examiner or condition resulting in death) Due to (or as a consequence of): Sequentially list conditions, if any, leading to immediate Due to (or as a consequence of): Examiner cause. Enter Underlying Cause (Disease or injury that initiated Due to (or as a consequence of): events resulting in death) Last Division of Vital Records, P.O. Box 68760, tall or Attending Physician: The law requires that the death certificate be executed burial - transi Physician/Medical UNPENDED AMENDED 23d Date of delivery IF FEMALE: 23c. If yes, outcome of pregnancy 23b. Was decedent pregnant in the Live birth 3 Ectopic pregnancy Fetal death past 12 months? Pregnant at time of Other (Specify) 1 Yes 2 No 9 Unknown death Unknown signed by the att be detached for 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. þ 1 Yes 2 No 3 Probably 4 V Unknown Completed 24a. Was an 24b. Were autopsy findings available certificate has been prior to completion of cause of autopsy performed' death? Yes 2 V No Fo the Hospital or Attending Physician: 25. Was case referred to medical 26.Place of Death (Check only one) Be Hospital: 1 Other:

Nursing Home 5 Residence 6 Other: Inpatient 2 V ER/Outpatient 3 DOA After this 1 🗸 Yes 27. Manner of Death 28d. Describe how injury occurred 28a. Date of Injury (Month, Day, Year) 28b. Time of Injury 28c. Injury at Work? Certification: 1 V Natural 1 Yes 2 No 5 Pending within 24 hours after death To the Funeral Director: the Accident 28f. Location (Street and Number or Rural Route Number, City 28e. Place of Injury - At home, farm, street, factory, office building, etc. Could not be Suicide or Town, State) Homicide 29a, Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. **Medical** Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier December 16, 2009 O.C.M.E.

111 Penn Street, Baltimore, MD 21201

ORIGINAL

State Registrar 30. Name and address of person who completed cause of death (Item 23a)

Assistant Medical Examiner

State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Margery Alda Jean MacMillan Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death Lonaconing 40 Main Street, Apt. 209 5. Social Security Number 24 Hrs. 8. Date of Birth (Month, Day, Year) December 10, 1930 6. Sex 7. Age (In yrs. last birthday) If Under 1 Year If Under **Funeral** 1 🗆 M 2 🔀 F Hours Days Director 376-32-1233 Usual Residence of Decedent be filed within 72 hours after death with the Maryland 10a. State 10b. County 10c. City, Town or Location at Director ed other than "natural", or items 23a or 28a-f s event, the Medical Examiner must be notified Lonaconing Allegany Maryland 10e, Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 21539 40 Main Street, Apt. 209 12. Was Decedent Ever in U.S. Armed Forces?, 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian Black, White, etc. 1 Yes 2 No If Yes, Give 1 Never Married 2 Married Completed by Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify: 3 Widowed 4 Divorced Year or Dates. 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) Homemaker O Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ပ Bessie LeeAnna Clark George Henry Metz 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Department of Hea. Important: If item 27 any injury or other once. 68 Jackson Street, Lonaconing, Maryland, 21539 Delsie Bolyard - Daughter 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date January 02 1 💆 Burial 2 🗆 Cremation 3 🗆 Removal from State cemetery, crematory or other place) Frostburg, Maryland Frostburg Memorial Park 2010 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Eichhorn-McKenzie Funeral Home P.A. 8 East Main Street 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final exacerba Physician/ tion disease or condition resulting in death) Medical Examiner Sequentially list conditions, Examine if any, leading to immediate cause. Enter Underlying Cause (Disease or linjury that initiated events Due to (or as a consequence of) Hospital or Attending Physician: The law requires that the death certificate be executed been signed by the attending physician and should be detached for use as the burial-transit Due to (or as a consequence of) resulting in death) Last Physician/Medical Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months?
1 ☐ Yes 2 ☑ No Pregnant at time of death 1 L Yes 2 L g Unknown Unknown P.O. Part II. <mark>Other significant conditions</mark> contributing to death but not resulting in the underlying cause given in Part I. Completed by Records, 1 🗹 Yes 24a. Was an page 2 performed/ Yes 2 N To the Hospital or Attending Physician: within 24 hours after death.

To the Funeral Director: After this certific completed filled in by the funeral director, **Division of Vital** 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Hospital: Other: 1 🗌 Yes 2 🗹 No 뎯 1 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at work? Certificate: Natural 5 \square Pending 1 🗌 Yes 2 No Accident Investigation 3 Suicide
4 Homicide Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) determined Medical 29a. Certifier

Lonaconing, MD 21539 Interval Between Onset and Death 23d. Date of delivery Day 23e. Did tobacco use contribute to the cause of death? 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 2 🗌 No 1 Tes 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 28d. Describe how injury occurred 28f. Location (Street and Number or Rural Route Number, City or Town, State) 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. who completed cause of death (Item 23a) (Type, Print) Cumporland Donald 4 31. Date filed (Month, Day, Year) 32. Registrar's Signature State Registrar **ORIGINAL**

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

Allegany

USA

Home

9. Birthplace (State or Foreign Country) Maryland

10d. Inside City Limits

White

1 Yes 2 No

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Month 746 Bonnie Jean Martin М Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death WMHS Regional Medical Center Cumberland Allegany Social Security Number 6. Sex If Under 1 Year If Under 24 Hrs. 8. Date of Birth Funeral 9. Birthplace (State or Foreign 1 □ M 2 💢 F Months Days Hours (Month, Day, Year) August 26, 1948 Country) Maryland Director 218-50-0657 61 Usual Residence of Decedent show permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f sho any injury or other traumatic event, the Medical Examiner must be notified at 10a, State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director 1 Yes 2 No Allegany Frostburg Maryland 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 21532 USA 10110 Crystal Lane 12. Was Decedent Ever in U.S. Armed Forces?

1 Yes 2 No
If Yes, Give Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian Black, White, etc. 1 Never Married 2 Married Completed by Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify: 3 Widowed 4 Divorced Specify. White Year or Dates 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) Chicken Plant Factory Worker Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) 2 Emma Jean Plummer James Hanlin 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Barbara Rafferty - Sister 10110 Crystal Lane, Frostburg, Maryland, 21532 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State cemetery, crematory or other place) 1 Burial 2 Cremation 3 Removal from State Cumberland, Maryland **Cumberland Crematory** 4 Donation 5 Other (Specify) Signature of Funeral Service Licensed 22. Name and Address of Facility Eichhorn-McKenzie Funeral Home P.A tsand 8 East Main Street Lonaconing, MD 21539 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final Onset and Death Ph. sician/ disease or condition resulting in death) Medical Due to (or as a consequence of) **Examiner** Sequentially list conditions, Examine if any, leading to immediate cause E ter or denying Cause (Disease or iinjury Due to (or as a consequence of) the Hospital or Attending Physician: The law requires that the death certificate be executed attending physician and for use as the burial-transit that initiated events Due to (or as a consequence of): resulting in death) Last Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery Ectopic pregnancy in the past 12 months? Month 4 Pregnant a 9 Unknown Dav Year Pregnant at time of death 5 Other (specify) 2 No 1 Yes 2 9 Unknown sate has been signed by the page 2 should be detached Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available 24a, Was an autopsy performed? Yes 2 No prior to completion of cause of death?

1 Yes 2 No To Be 25. Was case referred to medical 26. Place of Death (Check only one) examiner? 2 1 No 1 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify, within 24 hours after death.

To the Funeral Director; After this 28c. Injury at work?
1 ☐ Yes 2 ☐ No 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of Certificate: 28d. Describe how injury occurred Natural Accident 5 Pending Investigation 6 Could not be Suicide
Homicide . Place of Injury - At home, farm, street, factory, office building, etc. (Specify) filled in by 28f. Location (Street and Number or Rural Route Number, determined Medical 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a Certifier (Check 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) 02690 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Registrar
DHMH 17 Rev 7/2009

State

Dish Rood, Cumberland Manyland 21.502

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene for State 2009 Certificate of Death

12916

Physicia /Medica Examine

Funeral Director

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show amy injury or other traumatic event, I're Medical Exeminer must be notified at once.

Baltimore, Maryland 21215-0036

Physician /Medical Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Division of Vital Records, P.O. Box 68760,

										103.110.	- M		i free at	/ : ~
1	1. Decedent's Name	e (First, Middle, Las	MCTTO!	1/2				2.	Date of Dea Month)) Y	20	3. Time of De	eath
	(a. Facility Name (I	If not institution, give	e street and number)	1 7	. 1 2	4b. City, Town, o	Location of E	Death	10	Ac. 0	ounty of I	Death	0707	
	5. Social Security N		ex, 7. Age	(In yrs. last bi	rthday)	If Under I Year	If Under 24	Hirs. 8.	Date of Birtl	140	7776	. Birthpla	ice (State or F	oreign
	249-03- Usual Residence of	77601	M 2□F 5	4	Yrs.	Months Days	Hours	Min.	Date of Birtl (Month, Day	1955	Nc	Counti	Caroli	
	10a. State	10b. County		10c. City, Tow					· · · · · ·	1		10	d. Inside City I	
	MD 10e. Street and Nur	Garrett		Frien	asv1.	10f. Zip Code				10g. Citize	on of Mho	t Count	1 X Yes 2	□ No
runeral Director		ris Avenu	ıe .				531			-	USA	it Count	у:	
-nue	11. Marital Status	ied 2□ Married	12. Was Decedent E Armed Forces? 1 ∐Yes 2 ☑ N		13. Wa	as Decedent of H es, specify Cuba	lispani <i>c</i> Origin an, Mexi <i>c</i> an, F	? (Spe <i>c</i> if Puerto Ric	y Yes or No- an, etc.)	14	1. Race Black, V	America Nhite, et		
2	3 Widowed		If Yes, GiveX Year or Dates:		1 [∐Yes 2 ⊠ No	Specify:			5	Specify:	wł	nite	
blete		15. Decedent's Ed	de completed)		(Give kir	nt's Usual Occup nd of work done O NOT use retired	during most of	working		16b. Kind	of Busin	ess/Indu	ıstry	
Completed	Elementary/Seco	ndary (0-12) th	College (1-4or 5-	·	hef		,			Res	taura	ant		
10 De		(First, Middle, Last) chard Mori							irst, Middle, irgini		,			
		ame/Relationship (1	_	Address (Street Nationa						ate, Zip (1532	Code)	
	20a. Method of Disp		Removal from State	20b. Place o	of Disposit ery, crema	ion (Name of tory or other plac	ce)	Date	•	20c. Loca	ation - City	y or Tow	n, State	
1	4 ☐ Donation	5 ☐ Other (Specify	y)	Gasto		m. Park				Gast		•		
	21. Signature of F	meral Service Licen	flyman)		Name and Addre						es, 1536		
	23a. Part 1. Enter to shock, or hea Immediate Cause	ert ilure. List only	olications that caused one cause on each lin	the leath. Do	not enter	the mode of dyir	ng, such as ca	rdio Grr	espirator ar	rest,	30-21-1		Approximate Interval Betwe Onset and Dea	
	disease or condition resulting in death)		a Due to (or as	c n equence	of):	Myo,	ravelo	-	Mar	all to	N	1	favs	
	Sequentially list co	nditions,	b	1901	oun	(c' (au (Very	o pat	44				
	Sequentially list con if any, leading to im cause. Enter Unde Cause (Disease or that initiated events	nmediate erlying injury	Due to (or as a	consequence	01):			1	/	1				
EXG	resulting in death) I	Last	Due to (or as a	consequence	of):									
Medical		•	d											
	IF FEMALE: 23b. Was decedent		23c. If yes, outcome of		. 3∏E	etonic pregnanc	.,			23	3d. Date o	f deliver	у	
386	in the past 12 1 ☐ Yes 2 ☐ 9 ☐ Unknown	□No	4 ☐ Pregnant at 9 ☐ Unknown			Other (specify)	y				Month		Day Yea	ar
y y	Part II. Other signif	ficant conditions o	ontributing to death bu	t not resulting	n the unde	erlying cause giv	en in Part I.						cause of dea	
completed by		/ core	THUCK "	741/0		_		- 1		'es 2 □			bly 4 ☐ Uni	
2						<u></u>					dea	re autop: r to com th?]Yes 2	sy findings ava pletion of caus	allable se of
ב מ	25. Was case reference examiner?	red to medical					26. Place of	Death (0	1 □Yes Check only or			ites 2	Z LINO	
2	1 ☐ Yes 2 ☐			nt 2 ER/O			4 Li Nursi	ng Home	5 🗆 Resid	lence 6	□Other ((Specify)	1	
el IIIIcatioii.	27. Manner of Death 1 Natural 2 □ Accident	h 5 □ Pending investigation	28a. Date of Injur (Month, Day		Time of Injury	28c. Injur Wor	yat <br Yes 2 ∐ No		d. Describe h	ow injury	occurred			
3	3 ☐ Suicide 4 ☐ Homicide	6 Could not be determined		ry - At home, fa (Specify)	arm, stree				Location (S	Street and	Number o	or Rural	Route Numbe	r,
۱ د	29a. Certifier	1 Cartifulna Dh					mo d-t '	nlar:						
enical	(Check only one)	2 Medical Exan	ysician: To the best on niner: On the basis of and manner state	examination a	nd/or inve	stigation, in my	ppinion, death	occurred	at the time,	date and p	and mann blace, and	due to	the cause(s)	
Ē	29b. Signature and	title of certifier	1	1276	9	29c. Licens D-23				29d. Date		_		
-	30. Name and addr	essor erson who	completed cause of de	12.46 (Item 23a)						المارات	20, 2			
3	Robert A	Gorals	ci, M.D.,	,		*	land,	MD	21550					
	31. Date filed (Mon	th, Day, Year)		's Signature	B	Burthe							-	

State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month Mary Ann Olivari 2009 A M 5:22 Medical December 4a. Facility Name (if not institution, give street and number) Shady Grove Adventist Hospital 9901 Medical Center Drive Examiner 4b. City, Town, or Location of Death 4c. County of Death Montgomery Rockville, Maryland 5. Social Security Number 6 Sex . Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) Funeral 9. Birthplace (State or Foreign Country) Maryland 1 🗆 M 2 🕅 F Director 220-62-5829 28, Usual Residence of Decedent shov items 23a or 28a-1 snowner must be notified at 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director Montgomery 1 Yes 2 K No Rockville 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 20850 2621 Research Blvd. #116 USA filed within 72 hours after death 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian. Armed Forces Black, White, etc. ð 1 Never Married 2 Married 2 X No er than "natural", or the Medical Examir Yes If Yes, Give Year or Dates 1 ☐ Yes 2 K No Specify: 3 Widowed 4 M Divorced Completed Specify: White 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working al Hygiene. life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) US Government Post Office Clerk 12 traumatic event, Be Department of Health and Mental H Important: If item 27 is marked any injury or new 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) မ Ralph Piccolo Mazie Warfield 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 8170 Madrillon Court, Vienna, VA 22182 Billy Piccolo/brother 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date cemetery, crematory or other place. 1 Burial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify) National Memorial Park Dec.19, 2009 Falls Church, VA 22. Name and Address of Facility
National Funeral Home
7482 Lee Highway Falls Church, VA 22042 21. Signature of Funeral Service Lice MOlle Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Immediate Cause (Final disease or condition Onset and Death Physician/ Respiratory Failure Medical resulting in death) Due to (or as a consequence of) Examiner Morbid Obesity Sequentially list conditions, if any, leading to immediate cauca. Enter Underlying Cause (Disease or iinjury Examine Due to (or as a consequence of): Chronic Debilitation attending physician and for use as the burial-transit that initiated events Due to (or as a consequence of) resulting in death) Last Completed by Physician/Medical death certificate be yes, outcome of pregnancy

Live Birth 2 Fetal death 3 Ectopic pregnancy

Pregnant at time of cleath 5 Cathoric pregnancy IF FEMALE 23b. Was decedent pregnant 23d. Date of delivery in the past 12 months? 5 Other (specify) Month Day Year Pregnant at time of death Yes 2 X No signed by the a 1 Yes 2 2 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ※ Unknown 24b. Were autopsy findings available prior to completion of cause of autopsy performed? death? 1 ☐ Yes 2 ☐ No To the Hospital or Attending Physician: within 24 hours after death.

To the Funeral Director: After this certific completed filled in by the funeral director, 25. Was case referred to medical Be 26. Place of Death (Check only one) 1 Tyes Other: Certificate: To 2 No 1 A Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 🛚 Natural injury work? 1 ☐ Yes 2 ☐ No 5 Pending М Accident Investigation 6 Could not be Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, determined Medical 1 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certifie 29c. License number 29d. Date signed (Month, Day, Year) Varieble 00068080 December 12, 2009 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Registrar
DHMH 17 Rev 7/2009

State

31. Date filed (Month, Day, Year)

DEC 22 2009

Baltimore, Maryland 21215-0036

68760

Box (

P.O.

Division of Vital Records,

Sireesha Jalli - 9901 Medical Center Drive, Rockville, MD 20850

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Rolf Dieter Petzold 7:57 PM 2009 Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Washington Washington County Hospital Hagerstown 5. Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign Funeral March 20,1943 Months Days Hours Min. 592-30-4228 66 Director Germany Usual Residence of Decedent 28a-f shov 10a. State 10b. County 10d. Inside City Limits event, the Medical Examiner must be notified at 10c. City. Town or Location Director Hagerstown 1 Yes 2 No Maryland Washington 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? ö Funeral 23a 18911 Crofton Road 21742 USA items be filed within 72 hours after death 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11 Marital Status 14. Race - American Indian. Black. White, etc 1 Never Married 2 Married ō þ 1 Yes 2X No Baltimore, Maryland 21215-0036 1 Yes 2 No Specify: Specify: White "natural", 3 Widowed 4 XDivorced Completed Year or Dates 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15 Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) and Mental Hygiene. Elementary/Seconday (0-12) College (1-4 or 5+) Interior Designer Aircraft Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ပ္ Kaeszenz Hass permit. Page 1 and 2 should be Department of Health and Ment Important: If item 27 is marker any injury or other trainments Erich F. Petzold 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 18911 Crofton Rd. Hagerstown, Maryland 21742 Susan P. Lingerfelter (Fiance) 20b. Place of Disposition (Name of cemetery, crematory or other place)
Smithsburg Crematory 20a, Method of Disposition 20c. Location - City or Town, State December 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Smithsburg, Maryland 23, 2009 Signature of Funeral Service Licenser JLDavis Funeral Home 22. Name and Address of Facility MO1414 12525 Bradbury Ave. Smithsburg, Maryland 21783 Lee 23a. Part 1. Enter the disease, or complications that shock, or heart failure. List only one cause on aused the death. Do not enter the move of dying, such as cardiac or respiratory arrest, Approximate Interval Between Immediate Cause (Final Physician disease or condition resulting in death) Medical Due to (or as Examiner Gequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or linjury Examine Due to (or as a d that the death certificate be executed attending physician and for use as the burial-transi that initiated events Due to (or a a consequence of resulting in death) Last Medical P.O. Box 68760 IF FEMALE: yes, outcome of pregnancy
Live Birth 2 Fetal death Physician/ 23b. Was decedent pregnant 23d. Date of delivery Ectopic pregnancy in the past 12 months?
1 Yes 2 No Month 5 Other (specify) Pregnant at time of death signed by the a g 🗌 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Division of Vital Records, or Attending Physician: The law requires cate has been sig ; page 2 should b Completed 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of 24a. Was an autopsy performed death? this certificate 1 Yes 2 No 25. Was case referred to medical 26. Place of Death (Check only one) Be examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 1 No ဂ္ 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA within 24 hours after death.

To the Funeral Director: After thi
completed filled in by the funeral 27. Mann f Death 28a. Date of injury (Month, Day, Year) 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred injury Natural 5 Pending Accident 1 Yes 2 No Investigation 3 Suicide
4 Homicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) . Location (Street and Number or Rural Route Number, City or Town, State) determined Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certifie License number d. Date signed (Month, Day, Year) 36651

State Registrar 31. Date filed (Month, Day, Year)

Suile 200.

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

1161mm

32. Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Reg. No. 2 0 0 9 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month **Physician** 2009 10:50AM 16, Dec. Eugene Joseph /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death Examiner Garrett Grantsville 167 Blackberry Lane If Under 1 Year | If Under 24 Hrs. Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) 6. Sex Social Security Number **Funeral** Months Days Hours 1**∑**M 2□F 75 2/18/1934 Pennsylvania Director 193-24-6890 Usual Residence of Decedent permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show amy Injury or other traumatic event, the Medical Evamine, must be nutified at once. 10d. Inside City Limits 10c. City, Town or Location 10h County 10a. State 1 ☐ Yes 2 ☑ No Director Grantsville MD Garrett 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number U.S.A. 21536 167 Blackberry Lane by Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 1 K Yes 2 ☐ No 14. Race - American Indian, Black, White, etc. 11. Marital Status 1 Never Married 2X Married Baltimore, Maryland 21215-0036 1 ☐Yes 2 X No If Yes, Give Year or Dates: Specify: White 3 Widowed 4 Divorced Completed 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Shirt Factory Supervisor 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be McKenzie Pau1 Joseph В. 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 167 Blackberry Lane, Grantsville MD 21536 Gloria Paul/ Wife 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Salisbury Cemetery12/19/09 Salisbury, PA 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Newman Funeral Homes P.A. 179 Miller St., Grantsville, MD 21536 death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between Onset and Death 23a. Part 1. Enter the disease, or complications that caused the shock, or heart failure. List only one cause on each line Immediate Cause (Final **Physician** /Medical Examiner To the Hospital or Attending Physician: The law requires that the death certificate be executed Division of Vital Records, P.O. Box 68760, led by the attending physician detached for use as the buria

certificate has been signed by rector, page 2 should be detacl within 24 hours after death.

To the Funeral Director: A
completely filled in by the fu

- 1	disease or condition	- 00	1-9	10 Cle			mon	7/01/
	resulting in death)	Due to (or as a conseque	ence of):					
5	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	b. Due to (or as a conseque						
1	resulting in death) cast	Due to (or as a conseque	ence of):					
		.d						
ysicianimic	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	23c. If yes, outcome of pregnan 1 ☐ Live birth 2 ☐ Fetal (4 ☐ Pregnant at time of de 9 ☐ Unknown	death 3 Ectopic pr			23d. Date of de Month	livery Day	Ye ar
ca my r	Part II. Other significant conditions of	ontributing to death but not result	ting in the underlying ca	use given in Part I.	23e. Did tobacco	o use contribute to	o the cause of	
non Indian					24a. Was an autopsy performed? 1 □ Yes 2 ☑1	death?	utopsy finding completion of s 2 □No	s available cause of
0	25. Was c referred to medical			26. Place of Deat	th (Check only one)			
ם	examiner? 1⊠Yes 2∐No	Hospital: 1 ☐ Inpatient 2 ☐ E	ER/Outpatient 3 ☐ DO	A Other: 4 Nursing He	ome 5 Residence	6 ☐ Other (Spe	ecify)	
anolli.	27. Mann	(Month, Day, Year)	28b. Time of lnjury M	3c. Injury at Work? 1 ∐Yes 2 ∐No	28d. Describe how in	jury occurred		
	3 Suicide 6 Could not be determined	28e. Place of Injury - At hon building, etc. (Specify)	me, farm, street, factory,	office	28f. Location (Street City or Town, Sta	and Number or R ate)	ural Route Nu	imber,
מונמו	29a. Certifier 1 Certifying Pt (Check only one)	nysician: To the best of my know niner: On the basis of examinati and manner stated.	vledge, death occurred a ion and/or Investigation,	at the time, date and place in my opinion, death occu	e, and due to the cause irred at the time, date a	e(s) and manner a and place, and du	s stated. e to the cause	e(s)
1	29b. Signature and title of certifier		29c.	License number	29d. I	Date signed (Mon	th, Day, Year)	
	· Muse	/ lu	7 10	006180		12/18	109	
Q A	30 Name and address of person who	completed cause of death (Item		1950 - KI	EN R. P.	BUCTURE	ski h	10
	1 . 100 [10]	1411121 0414	1 -0	, , ,		- /	1	

DHMH 17 Rev 1/2001

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State

Registrar

31. Date filed (Month, Day, Year)

DEC 21 2009

oakland

32. Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

	State of Maryland / Department of Health and Mental Hygiene 1 - State Regulstrar Certificate of Death Reg. No. 2 0 0 9 4 2 9 2 0											
			Registrar			Cer	tificate c	of Dea	th	Re	g. No LUU	7 42720
	Physicia		Decedent's Name (First, Middle, La Helen	st) Elizabetl	h		Reed			2. Date of Death Month Decembe		3. Time of Death 1:55 P M
	Medic Examin		4a, Facility Name (if not institution, give					n or Loca	ation of Death	300050	4c. County of De	
	Examin	er	9114 Downsville						sport		Washin	
	Funeral		5. Social Security Number 6. S		ge (In yrs. last b	irthday)	If Under 1 Y		Under 24 Hrs.	8. Date of Birth	(oar) 9, E	Birthplace (State or Foreign
	Director		<u>219-20-3933 </u>	1 □ M 2 X F	86	Yrs.	WOITING	ays Ho	JUIII.	8/30/19	23 Ma	ryland
	d tow		Usual Residence of Decedent 10a. State 10b. County		10c, City, To	wn or Loc	ation					10d. Inside City Limits
	arylar a-fsh	cto			- "							1 🗆 Yes 2 🔀 No
	or 28, notif	Pire	Maryland Washing	ton	Willi	amsp	Ort 10f, Zip Co	de		1/	og. Citizen of What	
	/ith th	ra	9114 Downsville	Dileo				1795			U.S.A.	oodnity:
	ems r mu	Funeral Director	11, Marital Status	12. Was Decedent	Ever in U.S.	13. V			ic Origin? (Spe	cify Yes or No-		nerican Indian,
စ္	or it		1 Never Married 2 Married	Armed Forces?	(No			4	exican, Puerto	Rican, etc.)	Black, Wi	
21215-0036	within 72 hours after death with the Maryland giene. then "natural", or items 23a or 28a-f sho the Medical Examiner must be notified at	Completed by	3 Widowed 4 ☐ Divorced	If Yes, Give Year or Dates.		1 '	Yes 2	No Sp	ecity:		Specify:	White
5	"nat	ble	15. Decedent's I (Specify only highest g		16	(Give k		one during	most of worki	ng 1	6b. Kind of Busines	ss Industry
12	within 7 giene. ier than t, the M		Elementary/Seconday (0-12)	College (1-4 or	·		O NOT use reti	ired)				
	filed wi al Hygie d other event, th	வ	17. Father's Name (First, Middle, Last)		<u> </u>	lomem	aker	18	Mother's Name	e (First, Middle, Ma	<u>Domesti</u>	.с
Maryland	ge 1 and 2 should be filed within 72 hours after death with the Maryland tr of Health and Mental Hygiene. If item 27 is marked other than "natural", or items 23a or 28a-f show or other traumatic event, the Medical Examiner must be notified at	욘	Raymond Mort	<u>-</u>							shop	
ary	should and N is mai		19a. Informant's Name/Relationship (15	9b. Mailin	g Address (St				City or Town, State,	Zip Code)
	and 2 s Health s tem 27 i		Nancy J. Netz /	Daughter		9114	Downs	ville	Pike	Williams	port Mary	land 21795
ore	of He of He If item		20a. Method of Disposition 1 ■ Burial 2 □ Cremation 3 □	Romoval from State		of Dispos	sition (Name o	f place)	Г	Date 2	0c. Location - City	or Town, State
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89	endin use a	√/ue	IF FEMALE: 23b. Was decedent pregnant	23c. If yes, outcome	of pregnancy 2 Fetal dea	ath 3.	Ectopic preg	nancy			23d. Date of	delivery
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E .	ificati or, pa		25. Was case referred to medical				2	6. Place o	f Death (Check	1 Yes 2	No 1 🗆	es 2 No
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Division of Vital Records,	or Att fter de irecte n by t	Certificate:	3 ☐ Suicide 6 ☐ Could not I 4 ☐ Homicide determined			farm, stre	et, factory, off	ice		28f. Location (Stre City or Town,		Rural Route Number,
Ö	To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. Of the Funeral Director: After this certificate has been signed by the attending physician and completed filled in by the funeral director, page 2 should be detached for use as the burial-transit		29a. Certifier 1 Certifying Phy	/sician: To the best of	my knowledge	e death o	occured at the	time date	and place on	d due to the cause	e(s) and manner as	stated
	n 24 ho n 24 ho e Fun	Medical	(Check 2 Medical Examonly one) 3 Certifying Nu	niner: On the basis of e rse Practioner: To the	examination and best of my kno	d/or investi wledge, d	igation, in my o leath occurred	pinion, de at the time	ath occurred at ath atte and place	the time, date and e, and due to the c	place, and due to the ause(s) and manner	e cause(s) and manner stated. as stated.
	To th Withii To th	~	29b. Signature and title of certifier				29c. Lic	ense num	ber	29	d. Date signed (Mo	nth, Day, Year)
			massoul	· Gener				140	00		11419	010
	10		30. Name and address of person who MASSOUD 13. At	completed cause of d	leath (Item 23a ルム・ム	(Type, P	Frede	nick	st ,	tagersto	Wn. MD	21740
	Stat Registra	e ar	(Check only one) 3 Gertifying Nur 29b. Signature and title of certifier MUSSUS 30. Name and address of person who MASSOUD B. Address 31. Date flow Month, Pay Year	32. Registr	ar's Signatur	and of	0			U		

09-10119 Dorothy H. Royal Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible 2009 42921 State of Maryland / Department of Health and Mental Hygiene

December 28, 2000 Year December 28, 2000 Y		1- For State Certificate of Death Reg. No.									
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Physician Medical Examiner 228 Part Letter the disease, or complicative that caused the death. To not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final sease and all the caused the death. To not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final sease and thine. Immediate Cause (Final sease and thine. Immediate cause (Final sease and thine. Immediate cause Enter Underlying Cause (Disease or inputy into distillate). Sequentially list conditions: Sequentia	Page ment cant:		4 Donation 5 Other Specify.	The second secon	6-2010 N	EWPORT,	MD.				
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Moyano The Ghell O.C.M.E. December 27, 2009	To T	Med	and manner stated.	icense number	29	d. Date signed (M	onth, Day Year)				
aryone the shirt			Marie Andrews	D.C.M.E.							
() Name and address of person who completed cause of death (item 25a)			30. Name an address of person who completed cause of death (Item 23a)								
Margarita Korell MD. Assistant Medical Examiner 111 Penn Street, Baltimore, MD 21201	6			t, Baltimore, MD	21201						
State 31. Date filed (Month, Day Year) 32. Registrar's Signature			31. Date filed (Month, Day Year) 32. Registrar's Signature								

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

AMEND ITEM#20b, perFH, G899, 1/11/2010, WS
State of Maryland / Department of Health and Mental Hygiene 2009 For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ December 30, 2009 6:00 ртм Rachel Benjamin Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** Carroll Pleasant View Nursing Home Mount Airy 8. Date of Birth
(Month, Day, Year)
Jan 1, 1952 If Under 1 Year If Under 24 Hrs. 5. Social Security Number 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign **Funeral** Days 1 🗶M 2 🗆 F Months Hours Mary land Jan_ 216-60-8058 Director Usual Residence of Decedent ms 23a or 28a-f show must be notified at 10d. Inside City Limits 10b. County 10c. City, Town or Location

Mount Airy Director Maryland Carroll 1 🗌 Yes 2 🕱 No 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number U.S.A. 21771 Funeral 4101 Baltimore National Pike ral", or items ! | Examiner mus 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 12. Was Decedent Ever in U.S. rmed Forces?

XYes 2 \sum No 1970-Black, White, etc. ş 1 Never Married 2 Married Baltimore, Maryland 21215-0036 White 1 Yes 2 X No Specify: If Yes, Give Year or Dates Specify: Page 1 and 2 should be filled within 72 hours aft ment of Health and Mental Hygiene. ant. If item 27 is marked other than "natural", any or other traumatic event, the Medical Exa ury or other traumatic event, the Medical 3 Widowed 4 X Divorced Completed 1972 16a. Decedent's Usual Occupation
(Give kind of work done during most of working
life. DO NOT use retired)
Customer Service 16b. Kind of Business Industry Decedent's Education (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) Southern States Be 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) Sier ပ္ Rachel Sr Norma Fred Sylvester 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)
7504 Prospect Dr, Frederick, Maryland 21702 19a. Informant's Name/Relationship (Type, Print) Robert Roberson/P.O.A. 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State Date 2010 Department of h Important: If ite any injury or oth 1 Burial 2 X Cremation 3 Removal from State Jan2, -2009Smithsburg, Maryland Smithsburg Crematory | 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Lice 22. Keeney & Bastord P.A. Funeral Home 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. M00706 106 East Church St. Frederick, Maryland 21701 Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ Respiratory Arrest Minutes disease or condition resulting in death) Medical Due to (or as a consequence of) Exåminer Days Cerebrovascular event Sequentially list conditions. Examine if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Due to (or as a consequence of Years attending physician and for use as the burial-transit General Atherosclerosis that initiated events Due to (or as a consequence of) resulting in death) Last Be Completed by Physician/Medical Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy
5 Other (specify) in the past 12 months?
1 ☐ Yes 2 ☐ No Month Day Year Pregnant at time of death 1 Yes 2 9 Unknown g Unknown P.0. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Diabetes Mellitus; Cardiac Atherosclerosis; 1 ☐ Yes 2 🙀 No 3 ☐ Probably 4 ☐ Unknown Records, 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an Morbid Obesity; Hypertension; Seizures; certificate has birector, page 2 s autopsy performed' 1 Yes 2 No Knee replacements 1 ☐ Yes 2 🕱 No tal or Attending Physician: Thes after death.

I Director: After this certificated in by the funeral director, pa 25. Was case referred to medical 26. Place of Death (Check only one) Division of Vital Hospital Other: ဂ္ 1 ☐ Yes 2 🔀 No 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred Certificate: 1 Natural
2 Accident
3 Suicide
4 Homicide injury 5 Pending 1 Yes 2 No Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by determined within 24 hours a

To the Funeral D

completed filled i Hospital Medical Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated only one) 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) 00 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) M.D., 9501 Old Annapolis Road, Ellicot City, Maryland 21044 Melvin Joel Kordon 32. Registrar's Signature 31. Date filed (Month, Day, Year State

Registrar

JAN 1 1 2010

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

		-	For State Registrar	State of Ma	aryland		artmen <i>tificate</i>			and M	1ental Hy	gien Reg. N	2 1	09	429	923
	Physicia	n/	Decedent's Name (First, Middle, Las Gerardo C. DeLos	,	_						2. Date of De Month December	ath		Year	3. Time o	
~.~	Medic Examin		4a. Facility Name (if not institution, give						Location o		December	4	c. County		2.20 p	
	Funeral Director		010 10 0000	ex 7. Age	(In yrs. las	st birthday) Yrs.	If Under Months		If Under Hours	24 Hrs. Min.	8. Date of Bir OCL 20	th	T	9. Birth	olace (State o Inppine	
	Maryland 28a-f show	Director		pomery	10c. City,	Town or Lo	ver Spi									ity Limits
9	e filed within 72 hours after death with the Maryland that Hygiene. ed other than "natural", or items 23a or 28a-f show event, the Medical Examiner must be notified at	by Funeral Director	10e. Street and Number 11619 Veirs Mill Ro 11. Marital Status 1 □ Never Married 2 🏝 Married	12. Was Decedent Ev Armed Forces? 1 Yes 2				209 lent of Hi ify Cuba	spanic Ori n, Mexicar	, Puerto	cify Yes or No- Rican, etc.)	Ţ	Blac		ean Indian,	
Baltimore, Maryland 21215-0036	within 72 hours af giene. er than "natural" ; the Medical Exs	Completed by	3 Widowed 4 Divorced 15. Decedent's E (Specify only highest gr Elementary/Seconday (0-12)		+)	16a. Deced (Give life. D		al Occupa k done a	ation	_	ng	[Specify: Kind of Bu	isiness In		
yland 2	should be filed with and Mental Hygien is marked other th 'aumatic event, the	a	17. Father's Name (First, Middle, Last) Gonzalo Ravelo Delo	s Reyes		FIC	Sessor				e (First, Middle, ana Capay	Maider				
e, Mar	1 and 2 should be of Health and Ments fitem 27 is marked rother traumatic e		19a. Informant's Name/Relationship (7 Natalia DeLos Reyes / 20a. Method of Disposition		John Die		Veir	s Mil		, Sil	Route Numbe	ng, M	2090	2		
ıltimor	permit. Page 1 Department of I Important: If it any injury or o		1 ☐ Burial 2 ☑ Cremation 3 ☐ 4 ☐ Donation 5 ☐ Other (Speci	5/)	cei	metery, crer opolita	natory or or an Crer	ther plac	У	Dec	009 ¹ ,	Ale	Location - exandr	ia, V	A	
Ř	lmp any		23a. Part 1. Enter the disease, or comshock, or heart failure. List only of								ral Home , Silver		ing, M	D 209	Approxima Interval Bet	te tween
	Prrysician/ Medical Examiner	(t.)	Immediate Cause (Final disease or condition resulting in death)	Respirato Due to (or as a	ry Fai										Onset and	
9	ate be executed obysician and the burial-transit	dical Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter underlying Cause (Disease or iinjury that initiated events resulting in death) Last	b. Due to (or as a c. Pneumonia Due to (or as a Stage III	conseque	ence of):	c									
Box 687	death certific ne attending p ed for use as	/Me	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No g ☐ Unknown	23c. If yes, outcome of 1 Live Birth 2 4 Pregnant at 9 Unknown	2 Fetal	death 3	Ectopic p		у			()	23d. Dat	e of deliventh	,	Year
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Division of Vital Records,	or Attending Phys after death. Director: After this in by the funeral di	Certificate: To	1 Yes 242 No 27. Manner of Death 1 Natural 5 Pending 2 Accident Investigatio 3 Suicide 6 Could not be determined		y Year) 2 ry - At hom	28b. Time of injury	M 2	8c. Injury work 1 🗆	4 ∐ Nu rat	No	me 5 Resident Residen	now inju	ry occurre	ed		ber,
Δ	To the Hospital within 24 hours To the Funeral *Completed filled	Medical						death occured at the time, date and place, and due to the cause(s) and manner as st rinvestigation, in my opinion, death occurred at the time, date and place, and due to the edge, death occurred at the time, date and place, and due to the cause(s) and manner as 29c. License number 29d. Date signed (Mont				to the ca nner as st (Month,	use(s) and ma ated. Day, Year)	anner stat		
	5		30. Name and address of person who					4 64.	D663		MD 508.		cember	16,	2009	

Registrar

DHMH 17 Rev 7/2009

Physician/ Medical Examine Funeral Director permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the M-dical Examiner must be notified at once. To Be Completed by Funeral Director Baltimore, Maryland 21215-0036 Physician/ Medical Examiner Medical Certificate; To Be Completed by Physician/Medical Examiner To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completed filled in by the funeral director, page 2 should be detached for use as the burial-transit Division of Vital Records, P.O. Box 68760

Please Type or Pri		ndelible Ink. I artment of Hea		-	_	ible.
1 - For State Of IVI		rtificate of Dea		-	Reg. No. 2	00 1.2021
Decedent's Name (First, Middle, Last)				2. Date of Dea		3. Time of Death
ANGELA LOUISE RUBY				DECEMBI	ER 9 20	09 5:14A M
4a. Facility Name (if not institution, give street and number)		4b. City, Town, or Loc			4c. County	
	AL e (In yrs. last birthday)		Under 24 Hrs.	8. Date of Birt	h FREDE	9 Birthplace (State or Foreign
216-23-6304	37 Yrs.	Months Days H	lours Min.	May I,	1972	Maryland
Usual Residence of Decedent 10a. State 10b. County	10c. City, Town or Lo	cation				10d. Inside City Limits
Maryland Frederick	Mt.	Airy				1 ☐ Yes 2 🖾 No
10e. Street and Number		10f. Zip Code			10g. Citizen of W	Vhat Country?
6402 Woodville Road		2177				d States
11. Marital Status 12. Was Decedent I Armed Forces? 1 X Never Married 2 Married 1 Yes 2 X		Was Decedent of Hispa If Yes, specify Cuban, M	nic Origin? (Spe lexican, Puerto	city Yes or No- Rican, etc.)		e - American Indian, k, White, etc.
3 ☐ Wldowed 4 ☐ Divorced If Yes, Give Year or Dates.		1 ☐ Yes 2 🔀 No S	specify:		Specify:	White
15. Decedent's Education (Specify only highest grade completed)	(Give	dent's Usual Occupation kind of work done during	n ng most of worki	ng	16b. Kind of Bu	usiness Industry
Elementary/Seconday (0-12) College (1-4 or 8	ife. D	None			No	ne
17. Father's Name (First, Middle, Last)	I		. Mother's Name	e (First, Middle,	Maiden Surname	
Roger Lee Ruby			Ruth Ca	atherin	e Balsin	ger
19a. Informant's Name/Relationship (Type, Print)		ng Address (Street and				
Roger L. Ruby / Father 20a. Method of Disposition	20b. Place of Dispo					Maryland 20860 City or Town, State
1 ☐ Burial 2 ☑ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify)	cemetery, crer	matory or other place) Crematory		ember 2009		ck, Maryland
21. Signature of Funeral Sprvice Licensee						Homes, P.A.
10 V 15	8	E. Ridgevi	lle Blv	d. Mt.	Airy, M	Maryland 21702
Sequentially list conditions, b.	a consequence of):	er the mode of dying, si	uch as cardiac c	r respiratory an	est,	Approximate Interval Between Onset and Death
cause. Enter Underlying Cause (Disease or linijury that initiated events c.	a consequence of): a consequence of):					
IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 No 9 ☐ Unknown	2 Fetal death 3	Ectopic pregnancy Other (specify)			23d. Dat Mor	e of delivery nth Day Year
Part II. Other significant conditions contributing to death to Chronic Obstruction	eut not resulting in the t	underlying cause given i	in Part I.	23e. Did to	Yes 2 □ No	ibute to the cause of death? 3 Probably 4 Unknown Were autopsy findings available
25. Was case referred to medical		OC Plane		autor perfo 1 Yes	osy pormed? d	orior to completion of cause of leath?
examiner? Hospital:	ent 2 ER/Outpatie	Other	of Death (Check		dence 6 Othe	er (Specify)
27. Manner of Death 1 Natural 5 Pending 2 Accident Investigation	ry 28b. Time o	f 28c. Injury at work?			ow injury occurre	
3 ☐ Suicide 6 ☐ Could not be 4 ☐ Homicide determined building, et	ury - At home, farm, str c. (Specify)	eet, factory, office		28f. Location (S City or Tow		er or Rural Route Number,
29a. Certifier (Check only one) 1 Certifying Physician: To the best of 2 Medical Examiner: On the basis of e 3 Certifying Nurse Practioner: To the	xamination and/or inves	tigation, in my opinion, o death occurred at the tin	leath occurred at ne, date and plac	the time, date a e, and due to the	nd place, and due e cause(s) and ma	to the cause(s) and manner stated. Inner as stated.
29b. Signature and title of certifier MTeluso MP		29c. License nu	610		29d. Date signed	(Month, Day, Year)
30. Name and address of person who completed cause of a 1475 Tawey Ave	Frede	rick M	0 2	1702		1
	ar's Signature	parker				

State Registrar

Ì

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

		1	For State Registrar	State	of Marylan		artment of F rtificate of		d Menta	l Hygie _{Reg}	ne . _{No.} 2 0	09	42925
			1. Decedent's Name (First, Middle	e, Last)					2. Date Mon	of Death	Day	Year	3. Time of Death
	Physicia /Medic		H	UGH I	DUNN	STOWER	S		DE		17,	2009	6:54 A M
	Examin		4a. Facility Name (If not institution	n, give street and n	umber)		4b. City, Town, o	r Location of De	eath		4c. Count		
-			PRINCE GEORGE					EVERLY	Uro I o Date	-f Di-th			SEORGE 'S
	Funeral		5. Social Security Number	6. Sex 1 X M 2 □ F	7. Age (In yrs. I	last birthday) Yrs.	If Under 1 Year Months Days	If Under 24 Hours N	Min. 8. Date	of Birth	(ear)	Cou	
	Director		232-34-3652	Z 2	83	115.			AUG	. 22,	1926	WEST	VIRGINIA
	and and	-	Usual Residence of Decedent 10a. State 10b. County		10c. City	y, Town or Lo	ocation						10d. Inside City Limits
	Maryl f sho	ō	MD. PRINC	E GEORGE	10		SPRINGDA	LE.					ty∏Yes 2□No
	the 28a	Director	10e. Street and Number	E GEORGE	5		10f. Zip Code			10g	. Citizen of	What Cou	ntry?
	3a or		9202 ARDWI	CK ARDMO	RE RD.		20	0774			U	.S.A.	
	be filed within 72 hours after death with the Maryland Hygiene. d other than "natural", or items 23a or 28a-f show event, the Medical Exam in a matter to notified at	Funeral	11. Marital Status	12. Was De	cedent Ever in U.	S. 13.	Was Decedent of H	lispanic Origin	? (Specify Yes	s or No-		ce - Ameri	can Indian,
)	after or ite		1 ☐ Never Married 2 ☐ Mar	ried TYTYes	2 No	5_	1 ☐ Yes 21 No	Specify:	derio riicari, c		Speci		oto.
3	ral",	d b	3 ☐ Widowed 4 ☐ Divorced	Year or	Dates: 19						le in	WHI	
	72 h	Completed	15. Deceder (Specify only highe	nt's Education est grade completed	4)	(Give	edent's Usual Occup kind of work done	during most of	f working	16	Sb. Kind of E	Business/Ir	ndustry
4	ithin ne. han '	ᇤ	Elementary/Secondary (0-12)	College	(1-4or 5+)	lite.	DO NOT use retire					יטאכידג	RUCTION
1	e filed wall Hygie other t	ပိ	1017. Father's Name (First, Middle,	l ast)		L	BRICK L		Name (First,	Middle, Ma			COCITON
	l be fi ntal H ed of ed of	Be	•	Luciy	CTOLIED	C			ANNA	PEAR		GROV	/FC
Mai ylaild	2 should be filed n and Mental Hyg is marked other raumatic event, I	၉	JOHN 19a. Informant's Name/Relations	ship (Type Print)	STOWER		ing Address (Street						
2	d2s than t7 is i			ERS/SON			FLAT IRO						
ָ ט	ages 1 and 2 should b nt of Health and Ment t: If Item 27 is marked / or other traumatic e		EUGENE STOWE 20a. Method of Disposition	TROY DOM	20b. F		osition (Name of ematory or other pla		Date	20	Oc. Location	- City or T	own, State
5	Pages nent of int: If it		1 Burial 2 Cremation	3 Removal from	n State	-	-	i	2-21-20	na	DTVE	ז ז א ת ס י	E, MD
Dalilliole,			4 □ Donation 5 □ Other (S		I CH	1 2	CREMATO 2. Name and Addre	ess of Facility					
0	permit. Departr Imports any inji	0.09	M/M/Ch	anle	LAD MOO	091	CHAMBERS 5801 CLEV	FUNERAL FLAND A	J HOME	& CRE	EMATOR DALE:	KiUM,I MD. 7	2.A. 20737
			23a. Part 1. Enter the disease, o	r complications tha	t caused the deat								Approximate Interval Between
	Physician	1	shock, or heart failure. List Immediate Cause (Final	t only one cause or		rdic	ac Arr	thin	ia.				Onset and Death
•	Physician /Medical		disease or condition resulting in death)	a. Due 1	to (or as a conseq		0 / 1 1	7	Carc				
	Examiner												
	F #	Je.	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events	Due 1	o (or as a conseq	uence of):							
)	ocuted nd ransi	Examiner	Cause (Disease or injury that initiated events	С									
o o	e exe yan a urial-	Ĕ	resulting in death) Last	Due	to (or as a conseq	uence ot):							
0/0	Attending Physician: The law requires that the death certificate be executed in death. sector: After this certificate has been signed by the attending physician and by the funeral director, page 2 should be detached for use as the burial-transit.	dical		d									
Ď	eath certific attending p for use as		IF FEMALE:	23c If yes	outcome of pregn	ancy					224 [ate of deli	verv
S C	atten atten for us	Physician/Me	23b. Was decedent pregnant in the past 12 months?	1 Liv	e birth 2 Feta	al death 3	☐ Ectopic pregnan☐ Other (specify) _	су				Month	Day Year
j	he de	ysic	1 □Yes 2 □ No 9 □ Unknown	9 🗆 Ur		30447							
r.	w requires that the disbeen signed by the should be detached		Part II. Other significant condit	ions contributing to	death but not res	ulting in the	underlying cause gi	ven in Part I.	23	e. Did toba	acco use co	ntribute to	the cause of death?
2	uires n sigr Id be	d b								1 ☐ Yes	s 2∏No	3∏ Pr	obably 4 Unknown
necoras,	w req	Completed by							24	a. Was an		o. Were au	topsy findings available
ב	he law e has age 2 a	텵				-				autopsy perform ⊒Yes 2	ed?/	death?	completion of cause of 2 No
ā	an: T tifical tor, pa		25. Was case referred to medical	al				26. Place of	of Death (Chec				
>	ysici is cer direct	To Be	examiner? 1 ☐ Yes 2 ☑ No	Hospital:	Inpatient 2] ER/Outpati	ent 3 DOA Of	her: 4 🗆 Nurs	sing Home 5	Reside	nce 6 □ C	Other (Spe	cify)
0	ig Ph ter th neral	Ë	27. Manner of Death 1 ☑ Natural 5 ☐ Pendi		ate of Injury Ionth, Day, Year)	28b. Time Injury		ury at ork?	28d. D	escribe hov	w injury occ	urred	
Ö	ath. ath. Pr: Af	atic	2 Accident invest	tigation				∐Yes 2 □ No					
DIVISION OF VITAL	r Atterderinector	Certification:	3 ☐ Suicide 6 ☐ Could 4 ☐ Homicide deter	minod 200, Pla	ace of Injury - At h ilding, etc. <i>(Spe</i> c	ome, farm, s ify)	street, factory, office		28f. Lo	cation <i>(Str</i> ty or Town,	eet and Nu , State)	mber or Ru	ural Route Number,
)	ital curs af ral Di			BI	Ab a bassis of the	oude de c	ath angurer - Lit-	timo data and	I place and di	io to the co	alleg(a) and	manner	s stated
	To the Hospital or Attending Physician: The I within 24 hours after death. To the Funeral Director: After this certificate hat completely filled in by the funeral director, page	Medical	29a. Certifier 1 Certify (Check only 2 Medica	I Examiner: On th	the best of my kn e basis of examin anner stated.	owieage, de ation and/or	ath occurred at the investigation, in my	opinion, death	h occurred at t	he time, da	ate and plac	e, and due	to the cause(s)
	thin 2 the mple	Med	29b. Signature and title of certifi		anner stated.		29c. Licer	nse number		29	d. Date sig	ned (Mont	h, Day, Year)
	2						7	5818	12		12-	-18	-2009
,	V		30. Name and address of perso	n who completed o	ause of death (Ite	m 23a) (Tvn	e. Print)		·		-		
			C. DONALD		i.D.		HOSPITAL	DR., CF	HEVERT.	, MD	. 207	85	
	Sta	ate	31. Date filed (Month, Day,-Year	r) 37	Registrar's Sign								
	Regist	rar	DEC 22	2009	eleva 1	D. 490	all						

DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

		4	_ State	te of Maryland /	-	rtment of l		Mental Hy	giene Reg. No.2	19	42926	
			Registrar 1. Decedent's Name (First, Middle, Last)					2. Date of De	eath		3. Time of Death	
	Physicia		John Pierce Skilling	gs .				Month Decem	ber 20,	Year 2009	11:00 a M	
	Medic Examin		4a. Facility Name (if not institution, give street an	d number)		4b. City, Town, o	r Location of Dea		4c. County o	f Death		
	LXamiii	CI	Holy Cross Hospital			Silver	Spring		Moi	ntgom	lery	
	Funeral		5. Social Security Number 6. Sex	7. Age (In yrs. last b	irthday)	If Under 1 Year Months Days	If Under 24 Hr	24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign Min. (Month_Day, Year) Couptry)				
	Director		004-40-0230 1 Dxm 2	[⊥] F 78	Yrs.	Months Days	Hours Ivili	April	24, 1931	Country Main	le	
	T ow	1 1	Usual Residence of Decedent 10a. State 10b. County	10c. City, To	um or l oc	etion				100	d. Inside City Limits	
	yland -f sh ed a	[룡								1.00	1 🗆 Yes 2 🖼 No	
	e Mar r 28a notifi	1.= 1	Maryland Montgome 10e. Street and Number	ery S	11ve:	r Spring			10g. Citizen of WI	hat Countr		
	th th	la l	816 Loxford Terrace			2090	1		USA	100 0001111	, ·	
	within 72 hours after death with the Maryland glene. et than "natural", or items 23a or 28a-f show the Medical Examiner must be notified at the Medical Examiner must be notified.	Funeral		Decedent Ever in U.S.	13. V			Specify Yes or No		- Americar	n Indian.	
'	or ite	by F	Arm	ed Forces? Yes 2 \(\subseteq \) No	lf lf	Yes, specify Cub	an, Mexican, Pue	rto Rican, etc.)		, White, etc		
036	safte ral", Exan	힣	If Ye	es, Give r or Dates. 1954-7	6 1	Yes 2 No	Specify:		Specify:	Whi	te	
9-0	hour natu dical	Completed	15. Decedent's Education (Specify only highest grade comp		Sa. Deced	ent's Usual Occup	pation	orkina	16b. Kind of Bus	siness Indu	ıstry	
21	in 72 e. " nan "	틹	Elementary/Seconday (0-12) Coll	ege (1-4 or 5+)	life. DO	O NOT use retired,)			_		
7	led within Hygiene. other tha ent, the N			4	M	arine Sp	1		Federal		rnment	
pu	even	To Be	17. Father's Name (First, Middle, Last) Charles Winthrop Sk:	illings			1	_{ame (First, Middle} ordelia I	, Maiden Surname)			
<u>Z</u>	uld be I Mer narke natic									ata Zia Ca		
Maryland 21215-0036	of and 2 should be filed wired. Health and Mental Hygie fitem 27 is marked other rother traumatic event, the		19a. Informant's Name/Relationship (Type, Print Beverley Skillings/W						er, City or Town, Sta c Spring,			
	and healt		20a. Method of Disposition	20b. Place	of Dispo	sition (Name of		Date	20c. Location - 0	City or Tow	vn, State	
Jor	Page 1 nent of l ant: If its ury or of		1 🗋 Burial 2 🕱 Cremation 3 🗆 Remove	I from State ceme	tery, cren	natory or other pla itan Cre		Dec. 22, 2009	Silver	Snrin	ng,Maryland	
altimore,	permit. Page Department of Important: If any injury or once.		4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Fjuneral Service Licensee	1		_			-		ig, nary rand	
Ba	Depart any any		Dom Kle Collins	Mary	50	ancis J. O Univer	Collins	Funeral	Home In	c. ring.	MD 20901	
			23a, Part 1, Enter the disease, or complications	that caused the death. Do						,	Approximate	
70	Visite 1		shock, or heart failure. List only one cause	on each line.							Interval Between Onset and Death	
	Medical		disease of condition	Atherosclero		cardiova	SCULAR L	Isease		+		
11.0	Examiner											
		ner		ue to (or as a consequenc	e of):							
b	uted d ansit	ami	cause. Enter Underlying Cause (Disease or iinjury that initiated events c									
_	exec an an rial-tr	Ĕ	resulting in death) Last	ue to (or as a consequenc	e of):							
9	ite be executed hysician and the burial-transit	dical Examiner	d							+		
687	tifica ng ph	Physician/Me	IF FEMALE:									
9 ×	th cer tendi	ian	23b, was decedent pregnant	es, outcome of pregnancy Live Birth 2 Fetal de	eath 3	Ectopic pregnar	псу		23d. Date Mon	e of deliver oth	ry Day Year	
Box	deat the at red fo	sic	1 Vec 2 No 4	Pregnant at time of deat Unknown	h 5∟	Other (specify)						
P.O.	at the d by letach		Part II. Other significant conditions contribution	ng to death but not resultin	ng in the u	ınderlying cause g	iven in Part I.	23e. Did	tobacco use contri	bute to the	e cause of death?	
Э,	res th signe d be c	d b						1 🗆	Yes 2 No	3 🗆 Proba	ably 4 🖺 Unknown	
ğ	requil	ete						24a. Wa	s an 24b. W	Vere autop	sy findings available	
Records,	has has by	Completed by						_ aut	opsy p formed? d	leath?	npletion of cause of	
ĕ	The ficate		25. Was case referred to medical	<u> </u>		26.1	Place of Death (C.		2 2 No 1	☐ Yes 2	2 🗆 No	
/ita	sicial certi irecto	Be C	examiner? 1 Yes 2 No Hospital	: 1	/Outpotio	_ Lot	har		sidence 6 Othe	r (Specify)		
of Vital	Phy er this eral d	e: 1	27. Manner of Death 28a	. Date of injury 28	b. Time of	28c, Inju	ıry at		how injury occurre			
'n	ath. : Afte	cat	1 ☑ Natural 5 ☐ Pending 2 ☐ Accident Investigation	(Month, Day, Year)	injury	M 1	rk? Yes 2 No					
Division	Atte	Certificate;	3 Suicide 6 Could not be 4 Homicide determined	Place of Injury - At home building, etc. (Specify)	, farm, str	eet, factory, office			(Street and Numbe	r or Rural F	Route Number,	
ο	tal or s afte	log l										
	To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completed filled in by the funeral director, page 2 should be detached for use as the burial-transit	Medical	29a. Certifier 1 XXCertifying Physician: T	the basis of examination an	d/or inves	tigation, in my opir	nion, death occurre	ed at the time, date	and place, and due	to the caus	ise(s) and manner stated.	
	the H hin 24 the F	Me	only one) 3 Certifying Nurse Pract	ioner: To the best of my kn	owledge,	death occurred at t	the time, date and	place, and due to	the cause(s) and ma	nner as sta	ited.	
_			29b. Signature and title of certifier			29c. Licen	se number		29d. Date signed			
	A+1		(molyn)	er u		<u> </u>	VTO C)			- 20,2009	
-			30. Name and address of person who complete Carolyn Sporn, MD	ed cause of death (Item 23 1500 Fores	a) (Type, I	en Road,	Silver	Spring,	MD 20910	į.		
	Sta	ato-										
	Sta Registi		31. Date filed (Month, Day, Year) DEC 2 2 2009	32. Registrar's Signature	fo are	Lad.						

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month December Physician/ Day 18, 2009 Gladys Catherine Shifflett 8:35 pM Medical 4a. Facility Name (if not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Death Examiner Bowie P.G. Larkin Chase Nursing Home If Under 1 Year If Under 24 Hrs.
Months Days Hours Min. 5. Social Security Numbe 7. Age (In yrs. last birthday) 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** 1 M 2 X F Months Days Hours (Month, Day, Yearch 22, Country) Maryland Director 216-58-7152 91 March 1918 Usual Residence of Decedent show 10a. State 10b. County 10d. Inside City Limits 10c. City. Town or Location with the Maryland or than "natural", or items 23a or 28a-f sho the Medical Examiner must be notified at Director 1 🗌 Yes 2 🌁 No Maryland Silver Spring Montgomer 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funera USA 11506 Goodloe Road 20906 death 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 11. Marital Status 14 Race - American Indian. Armed Forces?

1 Yes 2 X No Black, White, etc. ⋧ 1 Never Married 2 Married Baltimore, Maryland 21215-0036 hours after Specify:White 1 Yes 2 No Specify: If Yes, Give Year or Dates 3 H Widowed 4 □ Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) al Hygiene. Elementary/Seconday (0-12) College (1-4 or 5+) 8 Homemaker Own Home Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) should be file and Mental F မ Blanch Viola Haagen permit. Page 1 and 2 should be Department of Health and Men Important: If item 27 is marke any injury or other traumatic o John William Patton 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 3504 Madonna Lane, Bowie, MD 20715 Nancy C. Reed/Daughter 20a. Method of Disposition 20b. Place of Disposition (Name of Date 23 20c. Location - City or Town, State cemetery, crematory or other place, 1 Burial 2 Cremation 3 Removal from State Dec. 2009 Norbeck Memorial Park 4 Donation 5 Other (Specify) Olney, Maryland 22 Name and Address of Eachlity Francis J. Collins Funeral Home 500 University Blvd. W., Silver 21. Signature of Funeral Service Licensee Inc. Spring, MD 20901 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final Onset and Death Physician Cancer of Esophagus disease or condition Medical resulting in death) Due to (or as a consequence of): **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Due to (or as a consequence of) Examir certificate be executed Cause (Disease or linjury that initiated events and tran Due to (or as a consequence of): resulting in death) Last g physician a Physician/Medical attending r IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy
 5 Other (specify) in the past 12 months?
1 Yes 2 No
9 Unknown The law requires that the death Month Day Year Pregnant at time of death ed by the a signed by the Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Hypertension, Anemia 1 Yes 2X No 3 Probably 4 Unknown Completed page 2 should peen: 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has autopsy performed? Yes 2 2 No certificate 1 ☐ Yes 2 ☐ No 25. Was case referred to medical 26. Place of Death (Check only one) Be examiner? Other: 1 🗌 Yes 2 🔀 No 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at work? Certificate: 28d. Describe how injury occurred 1 🔼 Natural 5 Pending

Division of Vital Records, P.O. Box 68760 in the fundant of the fundant of the fundant of the fundant birector. After this certific bomoleted filled in by the fundant director, To the Hospital or Attending Physician:

2 Accident Investigation 3 Suicide 6 Could not be 4 Homicide determined	28e. Place of Injury - At home, farm, street, fa building, etc. (Specify)	actory, office		(Street and Number or Rural Route Number, own, State)
(Check 2 Medical Examine)	an: To the best of my knowledge, death occur r: On the basis of examination and/or investigation Practioner: To the best of my knowledge, death	on, in my opinion, death occurred	at the time, date	e and place, and due to the cause(s) and manner stated
29b. Signature and title of certifier		29c. License number		29d. Date signed (Month, Day, Year)
· agns	n	D45217		December 18, 2009
30. Name and address of person who cor	pleted cause of death (Item 23a) (Type, Print)			
Abewole Ajayi, Mo	6201 Greenbelt Roa	d, College Par	k, MD 2	20740

State Registrar

Medical

31. Date filed (Month, Day, Year)

. Registrar's Signature artes

Hospital or Attending Physician: Division of Vital within 24 hours after death.

To the Funeral Director: A completely filled in by the fu To the]

				Tes 2 No 1	Y res 2 No
25. Was case referred to medical		26.	Place of Death (Check	only one)	
examiner? 1 ✓ Yes 2 No	Hospital: 1 Inpatient 2	ER/Outpatient 3 DO/	Other Nursi	ng Home 5 Residence 6	Other:
27. Manner of Death	28a. Date of Injury	28b. Time of Injury 286	. Injury at Work?	28d. Describe how injury occur	red
1 X Natural 5 Pending 2 Accident Investiga		1	Yes 2 No		
3 Suicide 6 Could no	ot be 28e. Place of Injury - At h	nome, farm, street, factory, o	fice building, etc.	28f. Location (Street and Numb or Town, State)	er or Rural Route Number, City
4 Homicide determin	(Specify)			Į:	2
29a. Certifier 1 Certifying Physi	ician: To the best of my knowled	dge, death occurred at the ti	ne, date and place, an	d due to the cause(s) and manne	r as stated.
one) 2 Medical Examin	er: On the basis of examination a and manner stated.	and/or investigation, in my o	inion, death occurred	at the time, date and place, and d	due to the cause(s)

29c. License number

O.C.M.E.

anto 30. Name and address of person who completed cause of death (Item 23a)

Assistant Medical Examiner 111 Penn Street, Baltimore, MD 21201 Margarita Korell MD.

Registra

DHMH 17 Rev 1/2001 OCME 2006

Medical

31. Date filed (Month,

29b. Signature and title of certifier

29d. Date signed (Month, Day, Year)

January 1, 2010

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) **Physician** 10:25 A M 2009 December 11, Verna Maria Sydney /Medical 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) Examiner Frederick Frederick 98 Siegel Court Birthplace (State or Foreign Country) 8. Date of Birth (Month, Day, Year) 7. Age (In vrs. last birthday 5. Social Security Number 6. Sex **Funeral** Months Days Hours 1 □ M 2 🔀 F 85 Sept. 10, 1924 Trinidad 074-42-2104 Director Usual Residence of Decedent 10d Inside City Limits 10c. City, Town or Location 10a State 28a-f show permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryla Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, To Maryland Evantime must be rutified at once. 1⊠Yes 2 No Director Frederick Maryland Frederick 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number 21702 United States 98 Siegel Court Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☑ No 11. Marital Status 1 ☐ Never Married 2 ☐ Married altimore, Maryland 21215-0036 If Yes, Give Year or Dates: 1 ☐ Yes 2 ☑ No Specify: Black þ 3₺Widowed 4 □ Divorced Completed 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) College (1-4or 5+) Elementary/Secondary (0-12) Nurse Health Care 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Morris Vincent Romano Henrietta Sydney 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) Siegel Ct., Frederick, MD Andrea Pemberton / Daughter Dec. 17, 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place)
Resthaven
Memorial Gardens 20a. Method of Disposition 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State 2009 Frederick, Maryland 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of uperal Service Licenses 22. Name and Address of Facility Resthaven Funeral Services, Skkot Cody P.A. 9501 Catoctin Mtn. Hwy. Frederick, MD 21701 23a. Part 1. Enter the disease, or complications that caused the shock, or heart failure. Its only one cause on each line. complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Immediat ause (Final disease condition resulting in death) 2-3 Week **Physician** Due to (or as a consequence of): /Medical Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner the Hospital or Attending Physiclan: The law requires that the death certificate be executed and the burial-trar Due to (or as a consequence of) P.O. Box 68760, physician Physician/Medical attending p for use as t IF FEMALE: 23c. If yes, outcome of pregnancy

1 Live birth 2 Fetal death
4 Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 - Ectopic pregnancy Day Month in the past 12 months? 1 □ Yes 2 No 9 □ Unknown 5 Other (specify) s been signed by the should be detached 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Division of Vital Records, 9 2 No 3 Probably 4 Unknown Be Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a Was an certificate has b irector, page 2 sl autopsy performed? Yes 2 No 2 No 1 ☐ Yes Dementio 1 ☐ Yes 26. Place of Death (Check only one) 25. Was case referred to medical examiner? funeral director Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 2 ER/Outpatient 3 DOA 1 Yes 2 No 1 Inpatient Certification: To this 28d. Describe how injury occurred 28a. Date of Injury (Month, Day, Year) 28h Time of 28c. Injury at Work? 27. Manner of Death 1 Natural 2 Accident 5 Pending investigation 1 ☐ Yes 2 ☐ No 6 ☐ Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State)

within 24 hours after death.

To the Funeral Director: A
completely filled in by the ft

State Registrar

Medical

4 Homicide

29a. Certifier (Check o one)

29b. Signature

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

and manner stated.

65-C Thomas Johnson Drive. Frederick, MD 21702 Hiren Shah, M.D.

32. Registrar's Signature 31. Date filed (Month, Day, 2009

title of certifier

EXECUTE Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Description of the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and due to the cause(s).

29c. License number

D 0051643

29d. Date signed (Month, Day, Year)

12/15/2009

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

		1	For State Registrar	State of Ma	ryiana / Dep Ce	artificate of D			Reg. No.	09	429	30
Phy	ysiciaı		1. Decedent's Name (First, Middle, Last)						ath	Year	3. Time of	
	Medic kamin	al -	Robert K 4a. Facility Name (if not institution, giv	Sr 4b. City, Town, or Location of Death			Decemb	mber 8 2009 6:40 P M				
	Karmin	31	Frederick Men	tal Frederick				Frederick				
	neral ector			Sex 7. Age 13€34M 2 ☐ F	(In yrs. last birthday) 57 Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birt (Month, Dat March	year 1952	9. Bir Pe 1	thplace (State of the puntry)	nia
land	dat		10a. State 10b. County		10c. City, Town or Lo						10d. Inside Ci	_
e Mary	notifie	je Ligita	Maryland Frederi 10e. Street and Number	ck	Thurmont	10f. Zip Code			10g. Citizen o	f What Co		2 🗆 No
with th	tal Hygiene. ad other than "natural", or items 23a or 28a-f show event, the Medical Examiner must be notified at	Funeral Director	15 Meadow Lan	ıe		217	88		USA	T WHAT O	Suriti y .	
21215-0036 within 72 hours after death with the Maryland giene.		Completed by Fun	11. Marital Status 1 ☐ Never Married 2 ☐ Married 3 ☐ Widowed 4 ☑ Divorced	12. Was Decedent Ev Armed Forces? 1 Yes 2 If Yes, Give Year or Dates.	ver in U.S. 13.	Was Decedent of His If Yes, specify Cubar 1 Yes XXNo		ecify Yes or No- Rican, etc.)		ack, Whit	erican Indian, te, etc. white	
5-00 2 hours "natur	dical	plete	15. Decedent's (Specify only highest g	Education	(Give	dent's Usual Occupa kind of work done do		king	16b. Kind of	Business	Industry	13
ithin 7.	9 4 5 C	S	Elementary/Seconday (0-12)	Callege (1-4 or 5-	-) life. E	OO NOT use retired) Stock	man		Foo	d se	rvice	
Maryland 21215-0036 2 should be filed within 72 hours after th and Mental Hygiene. 27 is marked other than "natural" of		To Be	17. Father's Name (First, Middle, Last, Charles L. Snu	18. Mother's Name (First, Middl Janet Eyler				, Maiden Surname)				
Marylish should be and Me			19a. Informant's Name/Relationship			ing Address (Street a	nd Number or Rui	ral Route Numbe				
e, Mand 2 s Health Health	ther tra		Robert Snurr, Jr 20a. Method of Disposition	- son	20b. Place of Disp	Carriage	Way, Fre	derick,			r Town, State	
Baltimore, permit. Page 1 and Department of Hea	jury or o		1 Burial 2 Cremation 3 Donation 5 Other (Spec	cify)	Blue Ric	natory or other place lge Cemete		4-2009	Thurmo	nt,	Marylan	ıd
Baltimo	any in		21. Signature of Funeral Service Lice	ule lle		2. Name and Addres						21702
Exan	dical niner	ledical Examiner	shock, or heart failure. List only one cause on each line. Interval Between Onset and Death Interval Betwe									
m 8 g	been signed by the attending physician and should be detached for use as the burial-transit	Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No g ☐ Unknown	23c. If yes, outcome of the live Birth of the li	2 Fetal death 3	☐ Ectopic pregnanc☐ Other (specify)	у		1	Date of de		Year
P.O. s that the		by	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death?									
rds, require	hould h	Completed	1							2 No 3 Probably 4 M Unknown 24b. Were autopsy findings available		
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of Vi ng Physi	after death. Director: After this c	ite: To	1 ☐ Yes 2 → No 27. Manner of Death 1 → Natural 5 ☐ Pending	1 Inpatie 28a. Date of injur (Month, Day	nt 2 L ER/Outpatient 3 L DOA 4 Nursing Home 5 L Residence 6 L Other (Specify) 28b. Time of 28c. Injury at 28d. Describe how injury occurred							
Sio (tten dear		Certificate:	2 Accident Investigati 3 Suicide 6 Could not 4 Homicide determine				(Street and Number or Rural Route Number, own, State)					
Hospita 24 hours	e runera leted fille.	Medical	29a. Certiffer (Check only one) 29a. Certiffirer (Check only one) 3 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 20 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.							anner stated.		
To the within 2	within 24 hours after To the Funeral Dire completed filled in b	2	29b. Signature and title of certifier	^ .		29c. License	number		29d. Date sig	ned (Mon	th, Day, Year)	
				e Vande			64910		12-			
1	0		30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Pratima Pandey, M.D. 400 W. 7th Street, Frederick, Maryland 21701									
R	State 31. Date filed (Month, Da TEC 1 5 2009. Registrar's Signature J. January J. January J.											

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. amend #18 Per FH G899 1/29/2010 JH State of Maryland 7 Department of Health and Mental Hygiene 1 - For State Registrar Reg. No. 2 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death DECEMBER 23, 2009 9:30A.M. Shank Rosalyn Marie 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death Washington Reeders Memorial Home Boonsboro Birthplace (State or Foreign Country) 5. Social Security Number If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 6. Sex 7. Age (In vrs. last birthday) Months Days Hours Min 1 □ M 2 🗓 F Maryland 216-76-7857 July 18, 1917 Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits 1 ☐ Yes 2 😿 No MD Washington Hagerstown 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 13701 Spring Valley Circle 21742 U.S.A. 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 ☐ Yes 2 No If Yes, Give Year or Dates: 1 ☐ Never Married 2 ☐ Married 1 ☐ Yes 2 X No Specify: Specify: 3 X Widowed 4 □ Divorced White 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) 12 Homemaker Domestic 18. Mether's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Howard James Daugherty Etitel Faye Shull 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Nevin M. Shank II/Son 13333 Marsh Pike, Hagerstown, MD 21742 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place, 20c. Location - City or Town, State 1 ☐ Burial 2 📈 Cremation 3 ☐ Removal from State Smithsburg Crematory 12/26/2009 5 ☐Other (Specify) 4 ☐ Donation Smithsburg, MD 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Rest Haven Funeral Chapel 1601 Pennsylvania Ave., Hagerstown, MD 21742 23a. Part 1. Enter the disease, or complication; that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final HISTORY OF PNEWMONIA 2 WEEKS disease or condition resulting in death) Due to (or as a consequence of): 1) LAMENTIA LARI. 47) VANICES Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of). Due to (or as a consequence of): IF FEMALE: 23c. If yes, outcome of pregnancy

1 Live birth 2 Fetal death
4 Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Year 5 Other (specify) 9 Hinknown 9 Unknow Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☑ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? 1 Yes 2 1900 2 🔀 No 1 Yes 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Tes 2 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 28d. Describe how injury occurred

Physician /Medical **Examiner**

Physician

/Medical

Director

Funeral

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Completed

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Examiner

Funeral

Director

ortant; If item 27 is marked other than "natural", or items 23a or 28a-f show Injury or other traumatic event, its Modical Exaction inside a routified at

permit. Pages 1 and 2 should be filed within 72 hours after death with 1 Department of Health and Mental Hygiene. Important; if item 27 is marked other than "natural" any injury or other trainment.

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the Hospital or Attending Physician: The law requires that the death certificate be executed

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Division of Vital Records, P.O. Box 68760,

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Certifica

Medical

27. Manner of Death 1 Natural 2 Accident

5 Pending investigation 6 □ Could not be 28a. Date of Injury (Month, Day, Year) 28b. Time of Injury

28c. Injury at Work?

1 ☐ Yes 2 ☐ No . Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a Certifier (Check only one)

3 🗌 Suicide

4 Homicide

1 Errifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier

29c. License number

29d. Date signed (Month, Day, Year)

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

GHAZALA QADIR, 20311 LAPPANS ROAD, BOONSBORO, MARYLAND 21713 301-432-8470

State Registrar 31. Date filed (Month, Day, Year)



n 24 hours after death.
he Funeral Director: A
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or Attending Physician: The law requires that the death certificate be executed Box 68760. P.O. Division of Vital Records. after death. within 24 hours a

To the Funeral C

> State Registrar

Medical

29a. Certifier

(Check only one)

29b. Signature and title of certifie

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30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29c. License number

29d. Date signed (Month, Day, Year)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Month ALDA ADEAN DECEMBER SCHAEFFER 2009 12:33 Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death HOMEWOOD AT CRUMLAND FARMS FREDERICK FREDERICK Social Security Number Birthplace (State or Foreign Country)
 Virginia 6. Sex 7. Age (In vrs. last birthday If Under 1 Year If Under 24 Hrs. Date of Div. (Month, Day, 8. Date of Birth **Funeral** Days Hours 1 M 2 X F Director 84 27-28-8071 Usual Residence of Decedent 28a-f shov 10a. State 10b. County 10c City Town or Location the Medical Examiner must be notified at 10d. Inside City Limits Director 1 Yes 2 No Maryland Howard Mount Airv ō 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral items 23a 21771 17650 Hardy Road 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Armed Forces? Black, White, etc ö 2 1 Never Married 2 Married Maryland 21215-0036 1 ☐ Yes 2 X No Specify: Yes. Giv "natural", 3 XWidowed 4 ☐ Divorced Specify: Completed Year or Dates White 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry الله filed with... عام Hygiene. عاد **than** "r (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) 2 should be filed withi th and Mental Hygiene 7 is marked other th 12 Homemaker Own Home Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) မ injury or other traumatic Walter William Cox <u> Mary Jane Harner</u> 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Page 1 and 2 sh Department of Health ar Important: If item 27 is any injury or other trau Betty Lou Chadwell, daughter 17650 Hary Road, Mount Airy, Maryland Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State X Burial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify) Mount Olivet Cemetery 12/15/2009 Frederick, Maryland 22. Name and Address of Facility Molesworth-Williams Funeral Home . Signature of Fureral Service 26401 Ridge Road, Damascus, Maryland 23a. Party. Enter the disease, or complications that & Ded the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Caus : (Final disease of condition resulting in death) Physician/ Due to (or as a consequence of): Medical Examiner Sequentially list conditions, Examine if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Due to (or as a consequence of): burial-transi that initiated events Due to (or as a consequence of) resulting in death) Last physician Physician/Medical certificate be Box 68760 attending IF FEMALE: use 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death
4 Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ for in the past 12 months?

1 Yes 2 No Pregnant at time of death signed by the a Id be detached f 9 Unknown 9 Unknown P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by Records, Dementio 2 No 3 Probably 4 Unknown 1 Yes To the Hospital or Attending Physician: The law require within 24 hours after death.

To the Funeral Director: After this certificate has been si completed filled in by the funeral director, page 2 should I 24b. Were autopsy findings available prior to completion of cause of 24a. Was an autopsy death? 2 No Be 25. Was case referred to medical **Division of Vital** 26. Place of Death (Check only one) examiner? 2 No Other: မ 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) 27. Manner of Death Certificate: 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred 5 Pending work? 1 ☐ Yes 2 ☐ No Natural Accident Investigation Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check only one) 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

State Registrar Hemen Shah 31. Date filed (Month Day Year)

DHMH 17 Rev 7/2009

32. Registrar's Signature

- British

Johnson Dr Frederick MD 21702

Please Type or Print in Black Indelible Ink. Ensure All Copies Are 4 egible State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month December 2009 3:42 p Vincent Tiegnon Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death Holy Cross Hospital Silver Spring Montgomery Social Security Number If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) Nov. 3, 1958 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign **Funeral** 216-77-8297 1**X**□ M 2 □ F 51 Months Days Hours Country)
Ivory Coast Director Usual Residence of Decedent Page 1 and 2 should be filed within 72 hours after death with the Maryland ment of Health and Mental Hygiene. ant: If item 27.7 is marked outher than "natural", or items 23a or 28a-f sho ant: If item 27.7 is marked outher than "natural", or items 25a or 28a-f sho ury or or other traumatic event, the Medical Examiner must be notified at 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director 1 Yes 2 No Maryland Montgomery Silver Spring 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 20906 14409 Banquo Terrace Ivory Coast 12. Was Decedent Ever in U.S Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian Black, White, etc. Completed by 1 Never Married 2 x Married 1 Yes 2X No If Yes, Give Baltimore, Maryland 21215-0036 Specify: Black 1 ☐ Yes 2X No Specify: 3 Widowed 4 Divorced Year or Dates 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) Elementary/Seconday (0-12) Embassy of the College (1-4 or 5+) Deputy Chief of Tourism 5+ Ivory Coast Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ည Robert Oulai Jolie Hortense Zregnon 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Marceline Tiegnon/Wife Banquo Terrace, Silver Spring, MD 20906 20c. Location - City or Town, State (Ivory Coast) 20a Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date Department of H Important: If ite any injury or ot Dec 20098, 1 Burial 2 Cremation 3 Removal from State Cimetiere de Williamsville 4 ☐ Donation 5 ☐ Other (Specify) Abidjan, Cote d' Ivoire 21. Signature of Funeral Service Licenses 22 Name and Address of Facility
Francis J. Collins Funeral Home Inc.
500 University Blvd. W., Silver Spring, MD 20901 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Interval Between Onset and Death Immediate Cause (Final Physician disease or condition Respiratory Arrest Medical resulting in death) Due to (or as a consequence of): Examiner Brain Edema Sequentially list conditions, Examine if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Due to (or as a consequence of) that the death certificate be executed Brain Tumor and the burial-tran that initiated events Due to (or as a consequence of) resulting in death) Last the attending physician the for use as the burial Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d, Date of delivery 3 Ectopic pregnancy in the past 12 months? Month Day 4 ☐ Pregnant at time of death 9 ☐ Unknown 5 Other (specify) Yes 2 No detached 9 Unknown by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. To the Funeral Director: After this certificate has been signed I completed filled in by the funeral director, page 2 should be det 23e. Did tobacco use contribute to the cause of death? Completed by Hospital or Attending Physician: The law requires 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 🎦 Unknown 24b. Were autopsy findings available prior to completion of cause of 24a. Was an autopsy death?
1 Yes 2 No 1 Yes 2 No æ 25. Was case referred to medical 26. Place of Death (Check only one) examiner?
1 Yes 2 No Other: 4 Nursing Home 5 Residence 6 Other (Specify) မ N Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at Certificate: 28d. Describe how injury occurred 5 Pending work? 1X Natural s after death 2 🗌 No Accident Investigation 6 Could not be Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, determined City or Town, State) To the Hospital within 24 hours a To the Funeral D Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check 29b. Signature and title of certifier 29c, License number 29d. Date signed (Month, Day, Year) MILLO 00 10 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 1500 Forest Glen Road, Silver Spring, MD 20910 Nooshin Farr, Md

State

Registrar

31. Date filed (Month, Day, Year)

DEC 22

Physicia /Medic Examin

Funeral Director

	1 - For State Registrar			of Marylai		ertifica					Reg. N	20	09	429	35
n al	1. Decedent's Name (Jennie	First, Middle, Las Mae	st)	Tren	am					2. Date of De Month Decemb		^{Day} 20 2	Year 009	3. Time of E	
er	4a. Facility Name (If n Moran Mane					1	y, Town, or stern	Location of	Death		4		ty of Death)	
	5. Social Security Num 220-32-448	35 1	ex [] M 2 [X F	7. Age (In yrs	. <i>last birthd</i> aj Yrs.		er 1 Year s Days	If Under 24 Hours	4 Hrs. 8 Min.	B. Date of Bir (Month, Da June 1	th 12, Yea 5 1	932	Cot	nplace (State or intry) Virgin	
tor	Usual Residence of Do	ocedent Ob. County Allegan	У		ity, Town or I	_ocation								10d. Inside City	
al Direc	10e. Street and Numb		lroad S	St.			Zip Code 21521				-		What Cou	-	
Be Completed by Funeral Director	11. Marital Status 1 □ Never Married 3 ➡ Widowed 4		12. Was Dec Armed Fo 1 _Yes If Yes, G Year or D	2 🔀 No ive	J.S. 13	i. Was Dec If Yes, sp 1 □ Yes		ispanic Origi In, Mexican, Specify:	in? (Spec Puerto R	ify Yes or No ican, etc.))-		ack, White,	ican Indian, etc. nite	
ompletec	(Specify Elementary/Second	5. Decedent's Ed only highest gradery (0-12)	ucation de completed) College ((Giv	edent's Us re kind of w DO NOT memak	vork done d use retired	ation during most (i)	of working	7		Kind of I	Business/II vork	ndustry	
	17. Father's Name (Fig.		QD.		1					First, Middle			ime)	_	
ဌ	19a. Informant's Nam	e/Relationship (7	Type. Print)			0		and Number	or Rural	Route Numb	er, City	y or Tow		. ,	
	Cora Grode 20a. Method of Dispos 1 Burial 2 XX	sition		20b. State	Place of Disp cemetery, cr	oosition (Neematory or	ame of other plac	e)	Rd, I 12/2		20c.	Location	- City or T	21521 own, State Marylar	
	4 ☐ Donation 5 21. Signature of Fune	☐ Other (Specify	<i>'</i>)	Cur	nberla:			ss of Facility	2009						<u></u>
	17-7	Vagne	150	rl		111 C	hurch	st,	West	ernpor	t.				
Examiner	23a. Part 1. Enter the shock, or heart 1 Immediate Cause (Findisease or condition resulting in death) Sequentially list conditions are senter underly Cause (Disease or injust in that initiated events resulting in death)	tions,	b. Due to	(or as a consector as a consector)	quence of):	hid	2-	form	tin	Technicity of	incost,			Approximate Interval Betw Onset and D	
edical	IF FEMALE: 23b. Was decedent prin the past 12 mm 1 □ Yes 2 2010 9 □ Unknown	regnant onths?	.d 23c. If yes, ou 1 □ Live	(or as a consection of pregration of pregration of pregration of pregration of pregration of the pregr	ancy al death 3	i □ Ectopio		/					eate of deli		ear
by Pr	Part II. Other significa	ant conditions co	entributing to d	leath but not res	sulting in the	underlying	cause give	en in Part I.				o use co		the cause of de	
Be Completed by Physician/M	Carcin	mer 1	Lu	y					_	24a. Was auto perfo 1 □ Yes		- 1	prior to c death?	opsy findings a ompletion of ca	vailable use of
	25. Was case referred examiner?		Hospital:				Othe	ar:		(Check only o					
tion: To	1 Yes 2 No. 27. Manner of Death 1 Natural 2 Accident	5 ☐ Pending investigation	28a. Date (Mor	Inpatient 2 of Injury oth, Day, Year)	28b. Time Injury	of	28c. Injury Work	y at	28	e 5 ☐ Resi 3d. Describe				ify)	
Medical Certification: 10		6 Could not be determined	28e. Place	e of Injury - At h ing, etc. (Spec	l iome, farm, s ify)	treet, facto			4	3f. Location (City or To	Street wn, Sta	and Nun ate)	nber or Ru	ral Route Numb	er,
dical	29a. Certifier 15 (Check only 2[one)	Certifying Ph	ni ner: On the b	e best of my kn basis of examin nner stated.	owledge, dea	ath occurre investigation	ed at the tir	ne, date and pinion, death	place, an	nd due to the d at the time,	cause date a	e(s) and a	manner as e, and due	stated. to the cause(s)	
ME	29b. Signature and title of certifier					29c. License number					29d. [Date sign	ed (Month	, Day, Year)	
	30. Name and address	J w	completed com	se of death (Ita	m 23a\ /Time		D2-1.	244			12	121	1200	39	
3	Dr. Jesus	Tan, 4	Broadw	ay, Fro	stbur		. 215	32							
e r	31. Date filed (Month	EC 22 2	009	Registrar's Sign	ature	had									

DHMH 17 Rev 1/2001

Stat Registra

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Rachel Jean Trail December II. 2009 4:50 p^M Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death 10140 Ke11y Road Walkersville Frederick 5. Social Security Number 9. Birthplace (State or Foreign **Funeral** 7. Age (In yrs. last birthday, If Under 1 Year If Under 24 Hrs. 8. Date of Birth July 18, 217-28-7341 1 □ M 2**X** F Months Days Hours Maryland Director 78 1931 Usual Residence of Decedent ral", or items 23a or 28a-f shov Examiner must be notified at 10a. State 10b. County 10c. City, Town or Location Director 10d. Inside City Limits Maryland | Frederick Walkersville 1 Yes XX No 10e, Street and Number 10f, Zip Code 10g. Citizen of What Country? Funeral 10140 Ke11y Road 21793 USA death 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 12. Was Decedent Ever in U.S. 14. Race - American Indian, Armed Forces?
1 ☐ Yes 2 🔼 No Black, White, etc 1 Never Married 2 Married Completed by Maryland 21215-0036 be filed within 72 hours after permit. Page 1 and 2 should be filed within 72 hours aft Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", any injury or other traumatic event, the Medical Exar 1 Yes 2 No Specify: white If Yes, Give 3 🗌 Widowed 4 🗌 Divorced Specify Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) Homemaker Own home Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Ezra Michael Flook, Sr. Rosa G. Hoffman 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Franklin Trail, Sr. - husband 10140 Kelly Road, Walkersville, Maryland 21793 Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State 1 ★ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) cemetery, crematory or other place Grossnickle Cemetery: 12-16-2009 Myersville, Maryland 22. Name and Address of Facility of Funeral Service Lice Stauffer Funeral Home seclis Opossumtown Pike, Frederick, Maryland 23a. Part 1. Inter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Interval Between Onset and Death WEEKS Immediate Cause (Final Physician/ CACHEXIA disease or condition Medical resulting in death) Due to (or as a consequence of): Examiner DBSTRUCTION MONTHS Sequentially list conditions, if any, leading to in reclate cause. Enter Underlying Examiner CANCER the Hospital or Attending Physician: The law requires that the death certificate be executed Cause (Disease or iinjury that initiated events ECTAL YEARS. the burial-tran Due to (or as a consequence of) resulting in death) Last physician Physician/Medical Division of Vital Records, P.O. Box 68760 attending p IF FEMALE 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ in the past 12 months?

1 Yes 2 No signed by the atte Day Year Pregnant at time of death Unknown g Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 2 LLCERATIVE COLITIS. Completed 1 Yes 2 No 3 Probably 4 Unknown page 2 should UTERINE CANCER 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has performed? Yes 2 No certificate 1 Yes 2 No 25. Was case referred to medica completed filled in by the funeral director, Be 26. Place of Death (Check only one) examiner? Hospital ပု 1 Inpatient 2 ER/Outpatient 3 IDOA 4 🗌 Nursing Home After this 27. Manner of Death 28a. Date of injury (Month, Day, Year) Certificate: 28b. Time of 28c. Injury at 28d. Describe how injury occurred 5 Pending iniury work? 1 ☐ Yes 2 ☐ No 24 hours after death. Funeral Director: A Accident Suicide Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 28f. Location (Street and Number or Rural Route Number, determined Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier

10

Registrar

DHMH 17 Rev 7/2009

State

(Check

29b. Signature and title of certifier

SADAF

31. Date filed (Month, Day

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

M-D

. Registra 's Signature

TAIMUR

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated

19

29c. License numbe

3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

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Division of Vital Records, P.O. Box 68760,

Baltimore, Maryland 21215-0036

6 Could not be determined 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Under the date and place, and due to the cause(s) and manner as stated.

Description of the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier (Check only one)

State Registrar

completely

Medical

George - Donald 31. Date filed (Mont

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

29b. Signature and title of certifier

DR. Cheverly, MD 20785 HOSPITAI distrar's Signature

29c. License number

29d. Date signed (Month, Day, Year)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.
State of Maryland / Department of Health and Mental Hygiene 2009 42938

Phyllis Marlene W	/illis S 1- For State Registrar	tate of Marylan		rtment of tificate of		and	Menta	al Hygie		20 eg. No.	09	42938	
Physician/ 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3.									3. T	ime of Death			
Medical Examine								De	ecember	Day Year 24, 2009		912 hrs	
	4a. Facility Name (if not instituti	1 -	ber)	1	4b. City, Tov		cation of	Death		1	Death		
	Frederick Memorial F		A		Frederi			In					
Funeral Director	5. Social Security Number 216-72-3146		Age (In yrs. la:	st birthday)	If Under Months	1 Year Days	If Under : Hours	Min		l F	3. Time of Death 0912 hrs 4c. County of Death Frederick W/DD/YYYY 9. Birthplace (State or Foreign Maryland Country) 10d. Inside City Limits 1 x Yes 2 No 14. Race - American Indian, Black, White, etc. Specify: Black Kind of Business/Industry Medical In Surname) City or Town, State, Zip Code) Maryland 21133 Location - City or Town, State rederick, Maryland eral Home rick, Maryland 2170 Approximate Interval Between Onset and Death Death Duse contribute to the cause of death? No 3 Probably 4 V Unknown 124b. Were autopsy findings available prior to completion of cause of death? No 3 Probably 4 V Unknown 124b. Were autopsy findings available prior to completion of cause of death? No 3 Probably 4 V Unknown 124b. Were autopsy findings available prior to completion of cause of death? No 3 Probably 4 V Unknown 124b. Were autopsy findings available prior to completion of cause of death? No 3 Probably 4 V Unknown 124b. Were autopsy findings available prior to completion of cause of death? No 1 V Yes 2 No Mence 6 Other: Jury occurred And Number or Rural Route Number, City		
Birector		1 M 2 F	50	Yrs				D	ec 15	, 1959	Country)	
any	Usual Residence of Decedent 10a. State 10b. County		10c. City.	Town or Locati						-	10d	Inside City Limits	
≥ .	Maryland Howa	rd		. Airy									
Maryland 28a-f show d at once.	10e. Street and Number				10f. Zip Co	ode			1 10	o Citizen of What	, i		
the Maryland a or 28a-f sh tifled at once	1044 Long Corn	er Road				2177	7 1			USA	oouy.		
vith th		12. Was Deced	lent Ever in U.S	13 Wa	s Decedent			2 (Specify	Yes or No-	14 Race -	American I	ndian Black	
eath vitem		Married Armed Force	es?		es, specify (, alan, Blask,	
ifter d		1 Yes vorced If Yes, Give Year	2 XX No	1	Yes 2	No s	specify:			Specify:	B1a	ck	
ours aft.	15. Decedent's Education (Spe	or Dates: ecify only highest grade	completed)	16a. Deceden					lone	16b. Kind of Busin	ness/Indus	try	
6 172 h an "n cal E	Elementary/Secondary (0-12)	College (1-4	or 5+)		ost of workin		ONOTUS	se retired)					
5-0036 ed within 72 hour lygiene. other than "natu the Medical Exar	E	1		ER Ass	istan						cal		
21215-0036 suld be filed within 7 Mental Hygiene. marked other than ic event, the Medica						18.				laiden Surname)			
2121 ould be fi ould be fi d Mental] s marked itic event,				I 19h Mailing	Address (Street o		th My		har City of Town	State Zin	Code	
imore, MD 21215-0036 Fages I and 2 should be filed within 72 hours after death with the Maryland men of Health and Mental Hygiene. Tant: If item 27 is marked other than "natural", or items 23a or 28a-f sho or other traumatic event, the Medical Examiner must be notified at once. To Be Commisted by Firmeral Director	Dorwick Smith												
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Baltimore, permit. Pages 1 a Department of He Important: If ite injury or other to	1 Burial 2 X Crematio			ematory or oth uffer(orv	i	12-31	-2009	Frederi	·k. M	arvland	
Baltimo Permit. Pag Department Important: Injury or ot	4 Donation 5 Other S 21. Signature of Funeral Services)		ame and Ad	_		_				ary rund	
Balt permit. Departi Import injury	Allange (anille.	Ellen									and 2170	
Physician											Ap	proximate Interval	
/Mr die al	23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock failure. List only one cause on each line. Immediate Cause (Final disease a. Hypertensive atherosclerotic cardiovascular disease)										Be		
Examiner	or condition resulting in death)	Due to (or as a co		CHCLOS	LICIO	-10 (carar	LOVABO	arar	4100400	_		
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ine	b if any, leading to immediate Due to (or as a consequence of): cause. Enter Underlying Cause												
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b. Box 68760 the death certificate by the attending physoched for use as the behasician/Me	1 Yes 2 No 9 🗸 Un	known 9 Unknown	1	3 O(iii	er (opeary)								
Division of Vital Records, P.O. Box 68760, rate of Attending Physician: The law requires that the death certificate be ris after death. al Director: After this certificate has been signed by the attending physic led in by the funeral director, page 2 should be detached for use as the burnerlification: To Be Completed by Physician/Med		tions contributing to de	eath but not res	ulting in the ur	nderlying ca	use give	n in Part I	1. 2	23e. Did tob	pacco use contribu	te to the ca	suse of death?	
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Sion Attendideath death ctor: by the f	1 X Natural 5 Pend 2 Accident Inves	ding stigation	1 Yes 2 No										
Division ospiral or Attending rours after death neral Director: Aftifiled in by the function: Certification:	3 Suicide 6 Coul	d not be 28e. Place of	f Injury - At hom	ne, farm, street	, factory, off	fice build	ling, etc		ocation (St		r Rural Ro	oute Number, City	
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	1000 0		/ //!).C.M.I				December 25	, 2009		
0	30 Name and address of person Russell Alexander MD	·			Penn Stre	eet Ra	altimore	MD 21	201				
State			trar's Signature					, IVID 4 1	-01				
Registra	1 9 SA FUL D 1 4	± 2010 /len	was j	y. Aga	Med					OCM	E		

State Registrar

JAN 1 1 2010 Sen S. Sares

32. Registrar's Signature

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Dr. Jocelyne Kouatchou MD

31. Date filed (Month, Day, Year)

12

Baltimore, Maryland 21215-0036

Division of Vital Records, P.O. Box 68760

6001 Muncaster Mill Rd. Rockville, MD 20855

			For State Registrar		State of IV	ıaryıar		artment rtificate			nental Hy	/gien Rea. Ne	2007	4	291	ŧ U
			1. Decedent's Name	(First, Middle, La	st)						2. Date of D	eath			Time of Dea	ath
Ш	Physici /Medi		Gabrielle	Jordann	e William	ıs					Decemb	er]	13, 2009		5:20 E	э М
and have	Examir		4a. Facility Name (If			r)		4b. City, To	wn, or Locati	on of Death		40	. County of Dea			
1			23943 Cat	awba Hil	1 Drive				rksbur	0			Montgon	nery		
	Funeral Director		5. Social Security Nu 220–85–77	83	Sex 7. A ☐ M 2 ☑ F	kge (In yrs.	last birthday) Yrs.	If Under 1 Months [Year If Un Days Hou 7	der 24 Hrs. rs Min.	8. Date of Bi (Month, D Nov. 6	rth ay, Year 20		rthplace country)	(State or Fo	oreign
	and ww		Usual Residence of D	Decedent 10b. County		10c. Ci	ty, Town or Lo	cation						10d In	side City Li	imits
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	r 28a	Director	10e. Street and Num	Montgo:	шегу		Clarks	10f. Zip C	ode			10g. C	itizen of What C	ountry?		
	th with	a	23943 Cat	awba Hil	1 Drive			208	71			Ur	nited St	ates	3	
	deat	Funeral	11. Marital Status		12. Was Deceden Armed Forces	t Ever in U	.S. 13. \	Nas Deceder	t of Hispanic	Origin? (Sp	ecify Yes or N Rican, etc.)	0-	14. Race - Am		dian,	
21215-0036	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show amy injury or other traumatic event, if a Redical Ever it are must be notified at once.		1X Never Marrie 3 ☐ Widowed 4	_	1 ∐Yes 21⁄x If Yes, Give Year or Dates] No		l∐Yes 2 ₂ E			nican, etc.)		Black, Whi	•		
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ary	shou and M s mar umat	-	19a. Informant's Nar	me/Relationship (Type. Print)		19b. Mailin	g Address (S					or Town, State,	Zip Code		-
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)	/Medical		resulting in death)	10	a. Respira Due to (or a			SS						3 ho	urs	
	Examiner		Sequentially list cond	titions	_{b.} Seizure	Epis	odes							2 da	ys	
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89	ertifica ing ph as th		IF FEMALE:						7.7							_
Вох	eath cert attendin for use a	ian/l	23b. Was decedent p		23c. If yes, outcome	2 🔲 Feta	al death 3	Ectopic pre				1	23d. Date of de Month	elivery Day	Year	r
Ö	Physiclan: The law requires that the death cer this certificate has been signed by the attendir ral director, page 2 should be detached for use	Physician/N	1 □ Yes 2 🔀 9 □ Unknown		4 ☐ Pregnant 9 ☐ Unknown		death 5	Other (spec	ify)				WORKE	Duy	Tour	
<u></u>	s that ned by detail		Part II. Other signific	cant conditions c	ontributing to death	but not res	ulting in the ur	derlying caus	se given in Pa	art I.	23e. Did	tobacco	use contribute	to the cau	use of death	h?
Records,	w requires been sign should be	ed by									1 🗆	Yes 2	P No 3□ F	Probably	4 🗌 Unkr	nown
000	law re as bee 2 sho	plet									24a. Was		24b. Were a	utopsy fi	ndings avai	lable
Œ Œ	The Tate his page	Completed									auto perfe 1 □ Yes	ormed?	death?		ion of cause No	3 01
Vital	siclan: Th certificate rector, pag	Be (25. Was case referre examiner?	d to medical						lace of Deat	h (Check only					
of	Physi this c	ဥ	1 ☐ Yes 2 🗽 N	lo			ER/Outpatien			Nursing Ho			6 ☐ Other (Sp	ecify)		
	ng ifter	ation	27. Manner of Death 1 Natural 2 Accident	5 Pending investigation		jury ay, Year)	28b. Time of Injury	М 28с	Injury at Work? 1 □ Yes 2	? □No	28d. Describe	how inju	ry occurred			
Division	To the Hospital or Attending within 24 hours after death. To the Funeral Director: After completely filled in by the funeral	Certification:	3 Suicide 4 Homicide	6 ☐ Could not be determined	200, Flace Of II	njury - At ho etc. (Specif	ome, farm, stre	eet, factory, o	fice		28f. Location City or To	Street a wn, Stat	nd Number or F e)	Rural Rou	te Number,	
	le Hospi 24 hou le Funer	Medical	29a. Certifier 1 (Check only 2 one)	Certifying Ph	ysician: To the bes niner: On the basis and manner s	of examina	owledge, death ation and/or inv	occurred at restigation, ir	the time, date my opinion,	e and place, death occur	and due to the red at the time	e cause(, date an	s) and manner and place, and du	as stated. le to the c	ause(s)	
	To th To th comp	Me	29b. Signature and til	tlesoficertifier	2			29c. L	icense numb	er		29d. Da	ate signed (Mon	th, Day,	Year)	
				(0	3.			D	05038	36		Dec	. 15, 20	009		
	1		30. Name and address		·			Print)								
			Dr. Nesto			7 Sene trærs Signa				Germa	intown,	MD	20876			
	Sta Registr		or, Date lifed (MONE)	nFC 1	7 2009 L	trair's Signa	380	park								

9-09635	D:		e or Print in Bla						jible.	
David Anthony -	- DIV	ead vveedon Sta 1- For State	te of Maryland /		tment of H ficate of D		d Mental H	lygiene ·	200	9 42941
Physici	an/	Registrar 1. Decedent's Name (First, Middle,	Last)	Oci al	ilcate of D			Re 2. Date of Death	g. No.	3. Time of Death
Medical Exam		David Anthony	Divead Wee	don				Month December	Day Year 11, 2009	0520 hrs
		4a. Facility Name (if not institution, N/B Baltimore Washing	give street and number)			City, Town, or a aurel	Location of Deat	n	4c. County of Dea	
Funeral		Social Security Number	6. Sex 7. Age	(in yrs. last		Under 1 Year			h(MM/DD/YYYY) 9. I	eian
Director		219-66-4468 Usual Residence of Decedent	1 X M 2 F	52	Yrs.	Months Days	Hours Mir	May 29	. 1957	Country) Maryland
* any		10a. State 10b. County		10c. City, To	own or Location					10d. Inside City Limits
Maryland 28a-f show d at once.	tor	Maryland Prince	George's	Laure						1 X Yes 2 No
more, MD 21215-0036 Pages I and 2 should be filed within 72 hours after death with the Maryland rent of Health and Mental Hygiene. nnt: If item 27 is marked other than "natural", or items 23a or 28a-f show or other transmatic event, the Medical Examiner must be notified at once.	Director	10e, Street and Number			10	f. Zip Code		10	g. Citizen of What Co	ountry?
ith the 23a conotif		9313-C Springhou	se Lane	Ever in II C	12 Mes De	207		pecify Yes or No-	United S	tates erican Indian, Black,
r death w or items must be	Funeral	1 Never Married 2 X Mar	ried Armed Forces?				, Mexican, Puerto		White, etc.	
fter de l'', or		3 Widowed 4 Divor	ced If Yes, Give Year	X No	1 Yes	2 X No	specify:		Specify:	Black
ours a atura	d by	15. Decedent's Education (Specif	or Dates: fy only highest grade com	pleted) 16	6a. Decedent's L				16b. Kind of Busines	
6 172 h an "n cal Es	Completed	Elementary/Secondary (0-12)	College (1-4 or 5	+)	during most o	of working life.	DO NOT use ref	ired)		
5-0036 led within 72 Hygiene. other than '	шc		5+		Wealth	Manag	er		Investme	ents
15-(filed I Hyg ed oth		17. Father's Name (First, Middle, L	,					e (First, Middle, M	laiden Surname)	
21215-0036 uld be filed within 7 Mental Hygiene. marked other than c event, the Medica	To Be	Charles W. Weed 19a. Informant's Name/Relationshi	on Sr.	T	19b. Mailing Ad	dress (Stree	Clara E	Barnes Rural Route Num	ber, City or Town, Sta	ate. Zip Code)
MD 2 Ind 2 shoul olth and N m 27 is m	_	Margaret Colden				,			teville. G	
re, I s 1 and f Healt If item er tran		20a. Method of Disposition			ce of Disposition	(Name of cen	netery,	Date	20c. Location - City	
MOP Pages ent of nt: If		1 Burial 2 X Cremation					Tna	. 19 00	Two dows of all	- Massalas 1
Wealth Manager 17. Father's Name (First, Middle, Last) Charles W. Weedon Sr. Clara Barnes 19a. Informant's Name/Relationship (Type, Print) Margaret Colden/ Wife 20a. Method of Disposition 1 Burial 2 X Cremation 3 Removal from State Margaret Colden/ Wife 20b. Place of Disposition (Name of cemetery, crematory or other place) Stauffer Crematory Inc. Dec. 18.09 Frederick 21. Signature Funeral Seprice Licensee 22. Name and Address of Facility Stauffer Funeral Homes P. A.										c. Maryland.
m 24 E :		Adel	Wmm	/	11621	Opossi	umtown H	ike. Fre	ederick. M	D21702
Physician /Medical		23a. Part I. Enter the disease, or co failure. List only one cause or	omplications that caused to n each line.	he death. Do	o not enter the m	ode of dying,	such as cardiac	or respiratory arre	est, shock, or heart	Approximate Interval Between Onset and
Examiner	1	Immediate Cause (Final disease	a. Multiple Injuries							Death
		or condition resulting in death)	Due to (or as a conse	quence of):						
	jer	Sequentially list conditions, if any, leading to immediate	Due to (or as a conse	quence of):						
	Examiner	cause. Enter Underlying Cause	C							
xecuted 1 and - transit	cal Exa	events resulting in death) Last	Due to (or as a conse	querice or):			·			
D, be ex sician	dic	UNPENDED	AMENDED							
Box 68760, steath certificate be exthe attending physician ed for use as the burial.	Physician/Medi	IF FEMALE: 23b. Was decedent pregnant in the	23c. If yes, outcom	e of pregnar	ncy 2 Fetal d	eath 3	Ectopic pregn	ancy	23d. Date of deliv Month	ery Day Year
x 68 h certi tendin use a	icia	past 12 months?	4 Pregnant at t	ime of death	_ =	(Specify)		апсу	None	Day real
Bo e deat the at ed for	hys	1 Yes 2 No 9 Unkno	9 Unknown				,			
Division of Vital Records, P.O. Box 68760, ral or Attending Physician: The law requires that the death certificate be executed its after death. al Director: After this certificate has been signed by the attending physician and led in by the funeral director, page 2 should be detached for use as the burial - transi	by	Part II. Other significant condition	ns contributing to death	but not resu	Ilting in the unde	rlying cause g	iven in Part I.			to the cause of death? robably 4 Unknown
ords, aw requir nas been s 2 should	Completed	1						24a. Was a		autopsy findings available
Reco The law cate has	m d	· · · · · · · · · · · · · · · · · · ·		-				autops perform 1 V Yes 2	m <u>ed</u> ? death	
ital Recision: The secretificate		25. Was case referred to medical	T		- -	26.Place	of Death (Check		2 No 1	Yes 2 No
Vita ysicia his ce direct	o Be	examiner? 1 Yes 2 No	Hospital: 1 Inpatier	nt 2 EF	R/Outpatient 3		Othor:		Residence 6 🗸 Ot	her: Scene
n of ding Ph. After t	Ë	27. Manner of Death	28a. Date of Injur (Month, Day, Ye Dec 11, 2009	y 26	3b. Time of Injury	1 '	y at Work?		ow injury occurred o involved in co	llioion
ion frendi feath. for:	aţi.	1 Natural 5 Pendin 2 Accident Investig	9 .		000 hrs	1_ Y	'es 2 ✓ No	Driver of aut	o involved in co	MISION
ivisior or Attence after death Director:	Certification:	3 Suicide 6 Could	not be 28e. Place of Inju			ctory, office b	uilding, etc.	28f. Location (S or Town, St		Rural Route Number, City
D sspital hours neral y filled	Ser	4 Homicide determ 29a. Certifier 1 Certifying Physical Ph	(oposity) Title					N/B Baltimore	Washington Parky	way @ Rt. 1, Laurel, MD
Divisic To the Hospital or Atter within 24 hours after dea To the Funeral Director completely filled in by th	ical	(Check only	sician: To the best of my iner:On the basis of exam							
To the within To the comple	Medical	29b. Signature and title of certifier	and manner stated			29c. License			29d. Date signed (I	
_			() 11	14		O.C.N			December 11,	
		30. Name and address of person w	ho com leted cause of de	ath (Item 23	sa)				,	
21			ty Chief Medical Ex	,		Street, Balt	imore, MD 2	1201		1
		31. Date filed (Month, Day, Year)	32. Régistrar	s Signature	1 Back					-
Regist	rar	DEC 15	2009 Gener	and la	7					

09-09635

			for State Registrar	State of Marylan	-	artment of F		nd Mental		ne N2 () () 9	429	42
Г	Physici	an	1. Decedent's Name (First, Middle, Last)					2. Date of	of Death	Day 2009	3. Time of	
*	/Medic Examir	cal	Oswald Zammichieli 4a. Facility Name (If not institution, give st	reet and number)		4b. City, Town, o	r Location of			18, 2009 4c. County of Death	9:35	A ^M
and the	Zami		Shady Grove Advent			Rockvil				Montgomer	9	
	Funeral Director		5. Social Security Number 6. Sex 1. 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1	7. Age (In yrs. I	ast birthday) Yrs.	If Under 1 Year Months Days	If Under 2	Min. 8. Date 6 (Mont	of Birth h, Day, Yea 20 ,	g. Birth Cou 1930 Penn	place <i>(Stat</i> e o <i>intry)</i> .sylvan:	ir Foreign ia
ı	land ow		Usual Residence of Decedent 10a. State 10b. County	10c. City	, Town or Lo	cation					10d. Inside Ci	
	e Mary 3a-f sh tified a	Director	Maryland Montgomer	y Derv	vood						1 🖾 Yes	2 □ No
	with th	Dire	10e. Street and Number 7613 Tarpley Drive			10f. Zip Code 2085	5.5			Citizen of What Cou ited Stat	,	
	ems 23	Funeral		. Was Decedent Ever in U.S Armed Forces?	S. 13. \	Vas Decedent of F f Yes, specify Cuba		in? (Specify Yes of		14. Race - Ameri Black, White,	ican Indian,	
036	should be filed within 72 hours after death with the Maryland of Mental Hygiene. marked other than "natural", or items 23a or 28a-f show imatic event, the Marylal Examiner must be notified at	by	1 ☐ Never Married 2 ☐ Married 3 ☑ Widowed 4 ☐ Divorced	Armed Forces? 1 ∑XYes 2 □ No If Yes, Give Kore Year or Dates:	ea i	∐Yes 21X No	Specify:		•/	Specific	nite	
Maryland 21215-0036	72 hou	Completed	15. Decedent's Educa (Specify only highest grade	tion completed)	(Give	lent's Usual Occup kind of work done	durina most d	of working	16b.	Kind of Business/Ir		
212	d within giene. Ir than	omo	Elementary/Secondary (0-12)	College (1-4or 5+)		00 NOT use retired cicklayer	•		C	onstructi	on	
pug	be filed ntal Hyg ed othe event,	Be	17. Father's Name (First, Middle, Last) Marcello Zammichie	1 -				s Name (First, M. Martini	ddle, Maid	en Surname)		
aryi	is 1 and 2 should b of Health and Ment item 27 is marked r other traumatic e	ပ္	19a. Informant's Name/Relationship (Type		19b. Mailin	g Address (Street			umber, City	y or Town, State, Zi	p Code)	
	l and 2 lealth a mm 27 is			ghter)	<u> </u>					ryland 20		
altimore,	Pages nent of hint: If ite		20a. Method of Disposition 1 ☑ Burial 2 ☐ Cremation 3 ☐ Rei 4 ☐ Dpnation 5 ☐ Other (Specify)	moval from State	$\mathop{\mathrm{AII}}\limits_{}^{ren}$	sition (Name of patory or other place of Ouls	ce) De	ecember : 2009	22 ,	Location - City or T		and
galti	permit. Pages Department of Important: If it any injury or once.	1	21. Signative of Funeral Service Licenses	A		. Name and Addre		DeVol F	ınera			
	σ□ = σ ο Ι		23a. Pa t1. E fer the disease, or complice shock, o keart failure. List only one	tions that caused the death						ersburg,	Approximate	е
1	Physician		shock, o bleart failure. List only one Immedi to Cluse (Final disease or condition	cause on each line. Cardiac Ar					,		Interval Bet Onset and D	ween
	/Medical Examiner		resulting in death)	Due to (or as a consequ	ence of):							
	p ±	iner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause Disease or injury that initiated events	Due to (or as a consequ	ence of):							
•	be executed cian and ourial-transit	Examiner	that initiated events c. resulting in death) Last	Due to (or as a consequ	ence of):							
۵/۵ م	icate be executed physician and the burial-transit	dical E	d.									
	leath certific attending pl	/Med	IF FEMALE:	:. If yes, outcome of pregnar	ncv					and Date of dall		
O. BOX	The law requires that the death certificate has been signed by the attending page 2 should be detached for use as	Physician/Me	23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	1 ☐ Live birth 2 ☐ Fetal 4 ☐ Pregnant at time of de 9 ☐ Unknown	death 3	Ectopic pregnanc Other (specify)	у		-	23d. Date of delive	•	Ye ar
	s that the med by e detacl	by Ph	Part II. Other significant conditions contr	buting to death but not resu	Iting in the un	derlying cause giv	en in Part I.	23e.	Did tobacco	o use contribute to t	the cause of d	leath?
ecords,	require een sig nould b	ted b							I □ Yes	2 No 3 Pro	bably 4 💢 L	Jnknown
S L	he law e has b	Completed						I	Was an autopsy performed? es 2 🕅 l	24b. Were auto prior to co death?	ompletion of ca	available ause of
	cian: T ertificat ctor, pa	BeC	25. Was case referred to medical examiner?				26. Place o	1 □ Y of Death (Check o		No 1 ☐ Yes	2 🗆 No	
5	Physi er this c eraf dire		1 ☐ Yes 2 ☐ No 27. Manner of Death	spital: 1 ☐ Inpatient 2 🔀 E 28a. Date of Injury	ER/Outpatien		4 LI Nurs			6 ☐ Other (Speci	ify)	
VISION	ending sath. or: Afte he fune	ation	1 ☑ Natural 5 ☐ Pending 2 ☐ Accident investigation	(Month, Day, Year)	Injury		ć? [™] Yes 2 □ No		ibe new m	gary boodings		
Š	lor Att after de Direct	Certification: To	3 ☐ Suicide 6 ☐ Could not be 4 ☐ Homicide determined	28e. Place of Injury - At hor building, etc. (Specify	me, farm, stre	et, factory, office		28f. Locati City o	on <i>(Str</i> eet r Town, Sta	and Number or Rur ate)	al Route Num	ber,
	To the Hospital or Attending Physician: The law requires that the dewithin 24 hours after death. within 24 hours after death. completely filled in by the funeral director, page 2 should be detached	Medical C	(Check only 2 Medical Examine	ian: To the best of my know	vledge, death	occurred at the tile restigation, in my o	me, date and opinion, death	I place, and due to n occurred at the t	the cause	e(s) and manner as and place, and due t	stated. to the cause(s	i)
	To the To the Comple	Med	one) 29b. Signature and title of certifier	and manner stated.		29c. Licens	e number		29d. [Date signed (Month,	, Day, Year)	
	4+1		Arrut Kee	MD		000	0640	68		12/18/0	, 9	
			30. Name and address of person who com Amit Kalaria, M.D.,			,	Rocks	ville. M	2081	50		
	Star Registra	te	31. Date filed'(Month, Day, Year) DEC 2 2 2009	00 D 11 1 01 1								
	ricgisti	A1	UEU 2 8 2009	persuas p.	d							

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Orpha R. Zimmerman December 2009 1:00 a.mM Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death Frederick Walkersville Glade Valley Nursing & Rehab Center Social Security Number If Under 1 Year If Under 24 Hrs. 7. Age (In yrs. last birthday) 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** Days 1 M 2 STF Months Hours 216-12-2189 (Month, Day, October 19, 1920 Maryland Director 89 Usual Residence of Decedent 28a-f shov 10b. County ral", or items 23a or 28a-f sho Examiner must be notified at 10a. State 10c. City, Town or Location Frederick 10d. Inside City Limits Director Maryland Frederick 1 XYes 2 ☐ No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral USA 21701 905 Motter Place death \ 11. Marital Status 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian. Armed Force Black, White, etþ 1 Never Married 2 Married 1 ☐ Yes 2 X No If Yes, Give Maryland 21215-0036 72 hours after white 1 ☐ Yes 2 K No Specify: ed other than "natural", event, the Medical Exar Completed 3XXWidowed 4 ☐ Divorced Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) d 2 should be filed within 72 alth and Mental Hygiene. Elementary/Seconday (0-12) College (1-4 or 5+) switchboard operator Banking Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ၉ Mary Alice Wiles Paul S. Rudy other traumatic 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code, Department of Health at Important: If item 27 is any injury or any Daphne A. Gough - niece 5004 Snow Drive, Frederick, Maryland Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place)
Stauffer Crematory 20c. Location - City or Town, State Date 1 Burial 2 X Cremation 3 Removal from State 12/15/2009 Frederick, Maryland 4 Donation 5 Other (Specify) 22. Name and Address of Facility Stauffer Funeral Home 21. Signature of Funeral Service License 21702 16210possumtown Pike, Frederick, Maryland 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line Immediate Cause (Final Onset and Death Physician/ disease or condition resulting in death) Medical Due to (or as a co Examiner Sequentially list conditions cause (Disease or linjury Due to (or as a consequence of) Exami Hospital or Attending Physician: The law requires that the death certificate be executed and -trans that initiated events resulting in death) Last Due to (or as a consequence of) physician sthe burial Physician/Medical Box 68760 attending p for use as t IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ____ in the past 12 months? Pregnant at time of death Month Day Year ☑ No 1 ☐ Yes 24 9 ☐ Unknown the Linknown Division of Vital Records, P.O. þ signed b significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 2 No 3 Probably 4 Unknown Yes 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy has page perform certificate 2 🗌 No Yes 2 No 1 \square Yes Be 25. Was case referred to medical 26. Place of Death (Check only one) No Hospital Other: 1 🗌 Yes |요 1 Inpatient 2 ER/Outpatient 3 DOA After this Nursing Home 5 Residence 6 Other (Specify) 27. Manner of Death 28a. Date of injury 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred Natural (Month, Day, Year) 5 Pending injury 1 Yes 2 No Accident Investigation within 24 hours after death

To the Funeral Director: completed filled in by the 1 Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office 4 Homicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined building, etc. (Specify) Medical Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basic of promiseing and/or inventioning in the control of the promise of promiseing and/or inventioning in the control of the promise of promiseing and/or inventioning in the control of the promise of promis 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check 3 🗆 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one 29b. Signature and title of certifier 29c. License number 30. Name and address of person who pleted cause of death (Item 23a) (Type, Print)

State Registrar 31. Date filed (Month, Day, Year,

32. Registrat's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Month 2009 December РМ 4:52 Dominick Lawrence Arleo Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** 4c. County of Death <u>Asbury Health Care Center</u> Calvert Solomons If Under 5. Social Security Number 7. Age (In yrs. last birthday) If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** (Month, Day, Year) 08-04-1920 Country)
New York Months Davs Hours Min 061-14-6543 89 **Director** Usual Residence of Decedent 28a-f show 10b. County 10a. State 10c. City, Town or Location 10d. Inside City Limits Examiner must be notified at Director MD Calvert Solomons 5 1 Yes 2 X No 10e. Street and Number ō 10f Zin Code 10g. Citizen of What Country? with items 23a Funeral 11750 Asbury Circle, Room 200 B 20688 United States 72 hours after death Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S 14. Race - American Indian Armed Forces?

1 🖾 Yes 2 🗌 No
If Yes, Give WW II
Year or Dates. Black, White, etc. ō 1 Never Married 2 X Married þ Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify: White "natural", Specify: 3 Widowed 4 Divorced Completed er than "natur , the Medical E 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) College (1-4 or 5+) 5+ Elementary/Seconday (0-12) Attorney Transportation 27 is marked other r traumatic event, the Be and 2 should be filed and Health and Mental Hy 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) 2 Unatainable Unatainable 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 4585 Graphic Drive, White Plains, MD 20695 Edward Lauman Step-Son item 2 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date Department of I Important: If its any injury or of once. 듇 1 X Burial 2 Cremation 3 Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 12-28-2009 Cheltenham, Maryland Vet. Cemetery Rausch Funeral Home, P.A. Signature of Funeral Service Licenses 22. Name and Address of Facility P. O. Box 600, Lusby, Maryland 20657 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, juch as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Ph. sician/ disease or condition Medical resulting in death) Examiner Sequentially list conditions, Examine if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Due to for as a consequence of To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director, After this certificate has boon almost a first and the certificate that the continue of the funeral Director after this certificate that the certificate the burial-tran that initiated events Due to (or as a consequence of) resulting in death) Last attending physician for use as the burial Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ in the past 12 months? Day Year Pregnant at time of death 2 should be detached 9 Unknown 9 Unknown Part II. **Other şignifiçant condition**s contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Be Completed by 1 Yes 2 No 3 Probably 4 Unknown Were autopsy findings available prior to completion of cause of death? 24a Was an page performed 1 Yes 2 No Yes 2 No 25. Was case referre o me examiner? 26. Place of Death (Check only one) 2 No မ 1 Tes 1 Inpatient 2 ER/Outpatient 3 DOA Nursing Home 5 - Residence 6 - Other (Specify 28c. Injury at work? Certificate: 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28d. Describe how injury occurred Natural injury 5 Pending 2 Accident
3 Suicide
4 Homicide 1 Yes 2 No Investigation within 24 hours after deatl

To the Funeral Director;

completed filled in by the 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, determined Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 29b. Signature and title of certif 29c. License number

Registrar

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

32. Registra s Signatur

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month **BOTTOMS** ROBERT 1:00 A M Decemb Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death LANHAM PRINCE GEORGE'S DOCTORS HOSPITAL . Social Security Number If Under 1 Year If Under 24 Hrs. **Funeral** . Age (In yrs. last birthday) 8. Date of Birth 9. Birthplace (State or Foreign 1 XM 2 □ F Days Hours FEB^{nth}1224, Yeg57 NEW"YORK Director 187-46-0991 52 Usual Residence of Decedent 28a-f shov 10a. State 10c. City, Town or Location the Medical Examiner must be notified at 10d. Inside City Limits Director 1 X Yes 2 No PRINCE GEORGE'S LANHAM 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? items 23a Funeral USA 6811 STORCH COURT 20706 12. Was Decedent Ever in U.S. Armed Forces? 1 Yes 2 No If Yes, Give Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian permit. Page 1 and 2 should be filed within 72 hours after c Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or is any injury or other traumatic event, the Medical once. Black, White, etc þ 1 Never Married 2 X Married Baltimore, Maryland 21215-0036 BLACK 1 ☐ Yes 2 No Specify. Completed 3 Widowed 4 Divorced Year or Dates 15. Decedent's Education 16a Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) CONTRACT SUPERVISOR PRIVATE Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) WHILIMENIA ROBERT BOTTOMS SMITH 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Cot 6811 STORCH COURT LANHAM, MARYLAND 20706 BARBARA A. BOTTOMS/WIFE 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Date 1 X Burial 2 Cremation 3 Removal from State 4 Donation 5 Cother (Specify) HARMONY CEMETERY 12/30/09 LANDOVER, MARYLAND J. B. JENKINS FUNERAL HOME 21. Signature of Funeral Service Licenses 22. Name and Address of Facility LANDOVER ROAD LANDOVER, MARYLAND 20785 23a. Part 1. Enter the disease or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Interval Between Immediate Cause (Final Onset and Death Physician/ disease or condition resulting in death) Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examine Due to (or as a consequence of) To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and Cause (Disease or iinjury the burial-tran that initiated events resulting in death) Last Due to (or as a consequence of) signed by the attending physician Be Completed by Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death
4 Pregnant at time of death
9 Unknown 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy
5 Other (specify) in the past 12 months?
1 ☐ Yes 2 ☐ No Month Day Year 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of 24a. Was an page 2 autopsy performed death? 2 No Yes 2 No 1 Yes 25. Was case referred to medical completed filled in by the funeral director, 26. Place of Death (Check only one) examiner's Other: ျှ 1 🗌 Yes 2 No 1 ☑ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 4 Nursing Home 5 Residence 6 Other (Specify) Manner of Death Certificate: 28a. Date of injury 28b. Time of 28c. Injury at 28d. Describe how injury occurred (Month, Day, Year) 1 Natural 5 Pending 2 Accident
3 Suicide
4 Homicide 1 Yes 2 No Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, determined City or Town, State) Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated, 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, uearn occurred at the time, date and place, and due to the cause(s) and manner as stated

Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29b. Signature and title of certifie 29d. Date signed (Month, Day, Year) 22 0050 95 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

State

Registrar

Date filed (Month, Day, Yea DEC 2 9 2009 KENILWORTH AUE

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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death Reg. No. 2 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ CAMPBELL SAXOLINE 2009 10300 M Vecen ber Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death DOCTORS HOSPITAL PRINCE GEORGE'S LANHAM Social Security Number 7. Age (In vrs. last birthday) Date of Birth (Month, Day, If Under 1 Year If Under 24 Hrs. **Funeral** 8. Date of Birth 9. Birthplace (State or Foreign 1 🗆 M 2 😾 F Days Hours Min. Director 88 MARY LAND 578-30-7049 1921 Usual Residence of Decedent 28a-f show 10a. State with the Maryland other traumatic event, the Medical Examiner must be notified at 10c. City, Town or Location Director 10d. Inside City Limits 1 X Yes 2 □ No PRINCE GEORGE'S COLLEGE PARK MD 10e Street and Number ō 10g. Citizen of What Country? Funeral 23a 20740 5000 PIERCE AVENUE USA 11. Marital Status 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. Black, White, etc. þ 1 Never Married 2 Married 1 Yes 2 No Baltimore, Maryland 21215-0036 1 Yes 2 No Specify: BLACK Completed 3 X Widowed 4 Divorced Year or Dates. 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business Industry (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) PRIVATE 12th COOK Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Department of Health and Mental I Important: If item 27 is marked o GEORGE P. BRISCOE ARLENE THOMAS 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 5000 PIERCE AVENUE COLLEGE PARK, MARYLAND 20740 CAMPBELL/DAUGHTER TRMA 20a. Method of Disposition 20b. Place of Disposition (Name of Page 1 g 20c. Location - City or Town, State 1 XBurial 2 Cremation 3 Removal from State cemetery, crematory or other place. any injury or 4 Donation 5 Other (Specify) 1/2/2010 NATIONAL CEMETERY LAUREL, MARYLAND 21. Signature of Funeral Service Licensee JENKINS FUNERAL HOME 22. Name and Address of Facility J. B. 7474 LANDOVER ROAD LANDOVER, MARYLAND 20785 23a. Part 1. Enter the sease, or complications that cause the shock, or heart failure. List only one cause on each line. th. Do not enter the mode of dying, such as cardiac or respiratory arrest, Immediate Cause (Final Onset and Death Respirator Physician/ disease or condition resulting in death) Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter underlying Cause (Disease or iinjury Examine Due to (or as a consequence of) burial-transi that initiated events resulting in death) Last Due to (or as a consequence of): attending physician for use as the buria Completed by Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death
4 Pregnant at time of death
9 Unknown 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? Day Year 5 Other (specify) 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Electoryte imsalance 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Renal failure 24b. Were autopsy findings available prior to completion of cause of death? 24a Was an autopsy performed 1 ☐ Yes 2 🛣 No 25. Was case referred to medical To Be 26. Place of Death (Check only one) examiner? 2 13 No Other: 1 npatient 2 ER/Outpatient 3 DOA 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 28a. Date of injury (Month, Day, Year) completed filled in by the funeral 27. Manner of Death Certificate: 28b. Time of 28c. Injury at 28d. Describe how injury occurred work? 1 🗌 Yes 2 🗌 No 1 Natural injury 5 Pending Accident Investigation M

P.O. Box 68760 Division of Vital Records, Hospital

State

Medical

6 Could not be

determined

Suicide

4 Homicide

29a. Certifier

(Check

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

who completed cause of death (Item 23a) (Type, Print)

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32. Registr

1 🖳 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29c. License number

28f. Location (Street and Number or Rural Route Number, City or Town, State)

		- C1-1-	epartment of Health and N Certificate of Death	Mental Hygiene Reg. No. 200	9 42947				
Physi				2. Date of Death Month Dec. 22, 2009	3. Time of Death 9:20 p M				
	dical niner		4b. City, Town, or Location of Death College Park	4c. County of D					
Funer Direct		5. Social Security Number 5. Social Security Number 6. Sex 1 ☒ M 2 ☐ F 7. Age (In yrs. last birth) 86 Y		8. Date of Birth 9.	Birthplace (State or Foreign Country)				
yland -f show ed at	ţ	Usual Residence of Decedent 10a. State 10b. County 10c. City, Town	or Location		10d. Inside City Limits				
ith the Mar 3a or 28a t be notifi	Funeral Director	Maryland P.G. Collection Street and Number 9203 Davidson Street	ge Park	10g. Citizen of What	1 🗆 Yes 2 🌁 No				
Datumore, Maryland 21213-0036 permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If time 27 is anarked other than "natural", or items 23a or 28a-f show any Injury or other traumatic event, the Medical Examiner must be notified at	d by Fune	1 Never Married 2 K Married 1 Yes 2 No	20740 13. Was Decedent of Hispanic Origin? (Spe If Yes, specify Cuban, Mexican, Puerto 1 ☐ Yes 2 ☑ No Specify:	Rican, etc.) Black, W	merican Indian, hite, etc. hite				
TZT 5-UU36 thin 72 hours after ane. than "natural", o	Completed	Year or Dates. 15. Decedent's Education (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) 12 Ta	Decedent's Usual Occupation Give kind of work done during most of work ife. DO NOT use retired)	ing 16b. Kind of Busine	ss Industry				
Yiand Z Jid be filed wi Mental Hygie narked other latic event, til	To Be C	17. Father's Name (First, Middle, Last)	l l	Clothing e (First, Middle, Maiden Surname) ria Caponiti					
, Mary Id 2 should salth and M n 27 is mai		19a. Informant's Name/Relationship (Type, Print) Teodora Chiedi/Wife 92	Mailing Address (Street and Number or Rura 03 Davidson Street,	al Route Number, City or Town, State, College Park, MD	Zip Code) 20740				
baltimore, bernit. Page 1 and Department of Hea mportant. If item any injury or othe	20a. Method of Disposition 1								
Demit permit Depart Impor any In	ouce	21. Signature of Funeral Service Licensee	² 2 Name and Address of Edithins 500 University Blv		ring, MD 20901				
Physician Medic		23a. Part 1. Enter the disease, or complications that caused the death. Do no shock, or heart failure. List only one cause on each line. Immediate Cause (final disease or condition resulting in death) Senile Dementia a. Due to (or as a consequence of	a	or respiratory arrest,	Approximate Interval Between Onset and Death				
Examine									
cate be executed physician and the bunial-transit	edical Examiner	Cause (Disease or injury that initiated events resulting in death) Last C	:						
Attending Physician: The law requires that the death certificate be executed a death certificate be executed as death. After this certificate has been signed by the attending physician and by the funeral director, page 2 should be detached for use as the burial-transit.	Physician/Me	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown 23c. If yes, outcome of pregnancy 1 ☐ Live Birth 2 ☐ Fetal death 4 ☐ Pregnant at time of death 9 ☐ Unknown	3 ☐ Ectopic pregnancy 5 ☐ Other (specify)	23d. Date of o	delivery Day Year				
v requires that to been signed be should be deta	þ	Part II. Other significant conditions contributing to death but not resulting in Hypertension, Diabetes Mellitus	the underlying cause given in Part I.	23e. Did tobacco use contribute 1 Yes 2 No 3					
The law rec cate has bee	Completed			autopsy prior t performed?performed?	autopsy findings available o completion of cause of ? /es 2 \(\sum \) No				
hysician: this certifical	To Be	25. Was case referred to medical examiner? 1		only one) me 5 🔀 X esidence 6 🗌 Other (Spe	ecify)				
Attending Ph death. ctor: After th	Certificate:	27. Manner of Death XX Natural 5 Pending 2 Accident Investigation 3 Suicide 6 Could not be	work? M 1 Yes 2 No	28d. Describe how injury occurred					
> 75.50		4 Homicide 4 Homicide 4 Homicide 4 Homicide 4 Be. Place of Injury - At home, farm building, etc. (Specify) 29a. Certifier 1 Certifying Physician; To the best of my knowledge, de		28f. Location (Street and Number or F City or Town, State)					
To the Hospital or At within 24 hours after or To the Funeral Direct completed filled in by	Medical	29a. Certifier (Check (Check only one) 3 Certifying Physician: To the best of my knowledge, de conly one) 3 Certifying Nurse Practioner: To the best of my knowledded 29b. Signature and title of certifier	ovestigation, in my opinion, death occurred at	the time date and place, and due to the	e cause(s) and manner stated. as stated.				
Ø		30. Name and address of person who completed cause of death (Item 23a) (Type	D58290	Dec. 23, 2					
		Suresh Kumar Muttath, MD 5711 A	Avenue, #200, Riverd	ale, MD 20737					
Regis	tate trar	31. Date filed (Month, Day, Year) DEC 2 4 2009 32. Registrar's Signiture	aster.						

State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death **Physician** Month Day Ann Marie Donovan 11:20 /Medical 2009 December 20. 4a. Facility Name (If not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death Prince George's Hospital Cheverly Prince George's 5. Social Security Number If Under 1 Year | If Under 24 Hrs. 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** 1 □ M 2 🖾 F Months Days Hours Yrs. 78 Director 213-44-7070 August 26, 1931 Cheverly, Usual Residence of Decedent permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, I'm Medical Examinating the matter and once. 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Directo Prince George's 1 X Yes 2 □ No Maryland Hyattsville 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 6808 Shepherd Street 20784 USA 13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 Never Married 2 X Married Baltimore, Maryland 21215-0036 ģ 1 ☐ Yes 2 No Specify Specify: White 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) 12 Banking Systems Manager 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be ٩ (Unav) (Unav) 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Eileen Donovan / Daughter 6808 Shepherd Street, Hyattsville, MD 20784 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 ☐ Burial 2 X Cremation 3 ☐ Removal from State Metropolitan Crematory 12/24/09 4 ☐ Donation 5 ☐ Other (Specify) Alexandria, Virginia 21. Signature of Funeral Service Licensee 22. Name and Address of Facility 4739 Baltimore Avenue Gasch's Funeral Home, P.A. Hyattsville, MD 20781 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** Massive Stroke disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Examiner Due to (or as a consequence of): spital or Attending Physician: The law requires that the death certificate be executed ours after death.

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The law specificate has been signed by the attending physician and filled in by the furneral director, page 2 should be detached for use as the buriar-transit resulting in death) Last Due to (or as a consequence of): P.O. Box 68760, Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 23b. Was decedent pregnant 23d. Date of delivery 1 Live birth 2 Fetal death
4 Pregnant at time of death 3 Ectopic pregnancy in the past 12 months? Month Day Year 5 ☐ Other (specify) been signed by the should be detached 1 ☐ Yes 2 🛛 No 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, \$ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☑ Unknown Completed 24a. Was an 24b. Were autopsy findings available prior to completion of cause of death? autopsy 2 □No 1 ☐ Yes 2 🔀 No 1 ☐ Yes 25. Was case referred to medical Be 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 TYes 2 TX No 1 Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 1 X Naturai 5 Pending investigation 2 ☐ Accident 1 ☐ Yes 2 ☐ No 6 Could not be 3 ☐ Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 ☐ Homicide Hospital To the Hospital within 24 hours a To the Funeral I completely filled 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) (Check only one) and manner stated. 29b. Signature and 29c. License number 29d. Date signed (Month, Day, Year) D64874 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 15 Shahab Zare Bavani, 10724 Little Patuxent Pkwy, Suite #200, Columbia, MD 21044 Date filed (Month. DEC 2 9 2009 32. Regi State Registrar

			for State	State	of Marylar				nd Mental Hy		00	12010		
			Registrar	(4)		Cer	tificate of l	Death		110g. 110.44	09	42949		
	Physicia	an/	1. Decedent's Name (First, Middle Linwood Beaut						2. Date of De Month	eath or 19, 2009	Year	3. Time of Death		
	Medic Examir		4a. Facility Name (if not institution	_	nber)		4b. City, Town, o	r Location of C				01:15 A M		
	LXaiiiii		Southern Maryla	•	,		Clinto		Jean I	4c. County		orge's		
	Funeral		5. Social Security Number	6. Sex 1 ፟ M 2 □ F	7. Age (In yrs.	last birthday)	If Under 1 Year Months Days	If Under 24		th	0 0:4			
	Director		231-32-5916 Usual Residence of Decedent	IESM 2 LIF	78	Yrs.	MOTHERS Days	Hours	Min. 09/13/	1931	Coun	Virginia		
	and show	ō	10a. State 10b. County		10c. Ci	ty, Town or Lo	cation					0d. Inside City Limits		
	Maryla 18a-f	Director	Maryland Calve	ert	Lus	sbv						1 ☐ Yes 2 🛱 No		
	a or 2	D	10e. Street and Number				10f. Zip Code			10g. Citizen of	What Coun	try?		
	th with ms 23 must	Funeral	12107 Gringo Ro				20657			United S	State	S		
	r deat		11. Marital Status 1 ☐ Never Married 2 ເສ Mari	Armed Fo			Vas Decedent of H Yes, specify Cuba	ispanic Origin? ın, Mexican, Pı	? (Specify Yes or No- uerto Rican, etc.)	1 11 1100	e - America ck, White, e			
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and	be file antal l ked o c eve	70 E	Leonard Beaufo	,					Name (First, Middle, n Beatric					
ary	nould ind M s mar umati		19a. Informant's Name/Relationsh	nip (Type, Print)		19b. Mailin	a Address (Street :		r Rural Route Numbe			ode)		
Σ	nd 2 sl salth a n 27 i ertra		Mary Elizabeth	Doss / Wi	fe				usby, Mar	-		000)		
Baltimore, Maryland 21215-0036	e 1 ar i of He if iten or oth		20a. Method of Disposition 1 ⅔ Burial 2 ☐ Cremation	3 Removal from	20b. i	Place of Dispos	sition (Name of latory or other place		Date	20c. Location -		wn, State		
tim	t. Pag tment tant: jury c		4 Donation 5 Other (S			et UMC C	emetery	12,	/26/2009	Lusby, M	aryland	i		
Bal	permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.		21. Signature of Funeral Service L	icensee) 22 P	Name and Addres	s of Facility	Rausch Fu	neral Ho	ome, F	P.A.		
			23a. Part 1. Enter the disease, or	complications that	dente				sby, MD 2					
Į,	nysician/		shock, or heart failure. List o Immediate Cause (Final	nly one cause on ea	ch line.	,	C	of the	and or respiratory ar	(C ^)		Approximate Interval Between Onset and Death		
	Medical		onset and Death isease or condition assulting in death) Due to (or as a consequence of): Onset and Death Onset and Death											
	Examiner		Common biglio lint non ditions		Dilat	(ng	Curdin	much	redtx					
	л ±	ine	if any, leading to immediate cause. Enter Underlying	Enter Underlying										
	and trans	Examiner	Cause (Disease or iinjury that initiated events resulting in death) Last	C. — Duo to	or as a consequ	myo	fundsqu	1 4	infarch.	m	10.07			
	To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. Within 24 hours after death. The funeral Director. After this certificate has been signed by the attending physician and completed filled in by the funeral director, page 2 should be detached for use as the burial-transit	edical E	resulting in death) Last	Due to	_	50000	Art	2. 1 T	DICAGEO					
Division of Vital Records, P.O. Box 68760	icate g physis the			d		so ory	01,16	7	7.2 (1.1.2)					
89	certif ending use a	Physician/M	IF FEMALE: 23b. Was decedent pregnant		come of pregna		Fatania annua			23d. Dat	te of delive	~		
Bô	death he atte	Sicis	in the past 12 months? 1 Yes 2 No		nant at time of		Ectopic pregnanc Other (specify)	У		Мо		Day Year		
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<u> </u>	an: Th tificat tor, pa		25. Was case referred to medical				26 Pla	ice of Death (C	1 \(\simeg\) Yes	rmed? c	☐ Yes 2	2 □ No		
<u> </u>	nysicii lis cer direc	일	examiner? 1 ☐ Yes 2 X No	Hospital:	npatient 2 🗆	ER/Outpatient	Otho	r.	g Home 5 Resid	ence 6 Othe	er (Specify)			
o o	ing Pt fter th ineral		27. Manner of Death 1 Natural 5 □ Pending	28a. Date		28b. Time of injury	28c. Injury work	at		ow injury occurre		-		
ion	ttendi death. tor: A the fu	2 Accident Investigation M 1 Yes 2 No												
M	after after Direction by	Certificate:	4 Homicide determine	ned 28e. Place	of Injury - At ho ig, etc. <i>(Specify</i>		et, factory, office		28f, Location (S City or Tow	treet and Numbe n, State)	r or Rural F	Route Number,		
	spita hours neral	ical	29a. Certifier 1 Certifying	Physician: To the b	est of my knowl	edge, death o	cured at the time,	date and place	e, and due to the cau	use(s) and manne	er as stated			
	the Hc in 24 the Fu	Medical	(Check 2 \square Medical E)	caminer: On the bas	s of examination	n and/or investig	action, in my opinio	1. death occurr	ed at the time, date a place, and due to the	nd place, and due	to the caus	se(s) and manner stated		
	Vith vith Co.		29b. Signature and title of certifier.	Mia.			29c. License	-		29d. Date signed	(Month, Da	ay, Year)		
			- Brit		M	D		2803	3	Decomb	er 2	1,2009		
RU	10+1		30. Name and address of person w	ho completed caus	of death (Item	23a) (Type, Pr	ant)	. DN	Suitall	21001:	nha	MM 11726		
V.	Stat	e	31. Date filed (Month, Day, Year)	32. Re	gistra s Signat	ure	CYTICUL	YNL	MINT	JIVOI	шоп,	TILL AU 10)		
П	Registra		DEC	23 2009	Deneus	J. B.	parker							

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 42950 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death December Margaret Garritsen de Vries 2009 12:20 pm 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Suburban Hospital Bethesda Montgomery 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign Michigan Michigan Months 1 M 2 X F Days Hours Yrs. 87 383-12-7030 Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Bethesda 1 Yes 2 X No Maryland Montgomery 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 10018 Woodhill Road 20817 u.s.A. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14. Race - American Indian, Armed Forces? Black, White, etc. 1 Never Married 2 X Married 1 ☐ Yes 2 No Specify: If Yes, Give Year or Dates Specify 3 Widowed 4 Divorced Caucasian 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) International Nonprofit Economist 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) John Garritsen Margaret Marie Ruggles 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Christine de Vries - Daughter 6800 Renita Lane. Bethesda, Maryland 20817 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State 1 🔀 Burial 2 🗆 Cremation 3 🗆 Removal from State cemetery, crematory or other place) 12/24/2009 | Rockville, Maryland 4 ☐ Donation 5 ☐ Other (Specify) Parklawn Mem. Park 22. Name and Address of Facility Hines-Rinaldi Funeral Home, 21. Signatur of Funeral Service Licensee MOIIO2 Kowe 11800 New Hampshire Ave., Silver Spring, MD 20904 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition

Physician/ Medical Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director, After this certificate has been signed by the attending physician and completed filled in by the funeral director, page 2 should be detached for use as the burial-transit

Division of Vital Records, P.O. Box 68760

Examiner

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permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at

be filed within 72 hours after death

Maryland 21215-0036

Baltimore,

Sequentially list conditions, ri any, leading to immediate cause. Enter Underlying Cause (Disease or linjury that initiated events resulting in death) Last

resulting in death)

Coronin Due to (or as a consequence of): Due to for as a consequence on Due to (or as a consequence of):

24a. Was an

autopsy performed

28d. Describe how injury occurred

IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 2 🛛 No 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

29a. Certifier

23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death Pregnant at time of death 9 Unknown

3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___

23e. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown

23d. Date of delivery

25. Was case referred to medical 2 No 1 🗌 Yes

Hospital 1 Inpatient 2 2 ER/Outpatient 3 DOA 28a. Date of injury (Month, Day, Year) 28b. Time of

Yes 2 No 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify,

24b. Were autopsy findings available prior to completion of cause of death? 2 🗆 No 1 Yes

Day

Year

27. Manner of Death 1 Matural 5 Pending Accident Investigation Suicide 6 Could not be 4 Homicide determined

iniury 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28c. Injury at work' 1 Yes 2 No

Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

28f. Location (Street and Number or Rural Route Number, City or Town, State)

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one) 29b. Signature and title of certifier D66896

066896

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

8600 Old Georgetown Road, Bethesda, Maryland 20814 Matthew M. M.D.. Leonard. 31. Date filed (Month, Day, Year)

State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Audithia Bernadith Davis 8:25 pm December 2009 Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death <u> 2</u>026 University Blvd., Silver Spring Montgomery Social Security Number 7. Age (In vrs. last birthday If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign Country)

Jamaica **Funeral** 1 M 2 X F Months Days Director 49 0870671960 578-88-4786 Usual Residence of Decedent 28a-f show ms 23a or 28a-f shomust be notified at 10c. City, Town or Location 10d. Inside City Limits Director 1 X Yes 2 No Maryland Montgomeru Silver Spring 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 2026 University Blvd., West 20902 U.S.A. 12. Was Decedent Ever in U.S. Armed Forces?
1 ☐ Yes 2 ☒ No If Yes, Give 11. Marital Status 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, the Medical Examiner <u>۾</u> 1 Never Married 2 X Married Maryland 21215-0036 1 ☐ Yes 2 X No Specify: "natural", Completed 3 Widowed 4 Divorced Sperikrican-American Year or Dates. 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Industrial Bank Elementary/Seconday (0-12) College (1-4 or 5+) Banker of Washington Be Should be file and Mental H 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ၉ Bartley E. Brown Hazel V. Hylton Lege 1 and 2 sh.
Legartment of Health and
Important: If item 27 is many injury or other. 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Thomas Davis - Spouse 2026 University Blvd.. West. Silver Spring, MD 20902 Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Date 1 Burial 2 K Cremation 3 Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Lincoln Crematory 12/29/2009 Brentwood, Maryland 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Simple Tribute Funeral Home 1040 Rockville Pike, Rockville, MD 23a, Part 1. Enter the dise se, or mplications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest one cause on each line. Approximate shock, or heart failure Immediate Cause (Final set and Deat Physician/ .5 months disease or condition resulting in death) Liver Failure Medical Examiner Metastatic Breast Cancer 2.5 years Sequentially list conditions, if any, leading to immediate Due to (or as a consequence of): cause. Enter Underlying Cause (Disease or iinjury that initiated events resulting in death) Last Exami Due to (or as a consequence of): attending physician for use as the buria Physician/Medical Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ____ in the past 12 months? Day Year Pregnant at time of death Yes 2 No 9 Unknown 9 X Unknown P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 호 Records, 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has performed? Yes 2 X No 2 🗌 No 1 Yes Vita 25. Was case referred to medica Be 26. Place of Death (Check only one) examiner? Hospital: Other: 욘 1 Inpatient 2 ER/Outpatient 3 DOA 4 ☐ Nursing Home 5 **X** Residence 6 ☐ Other (Specify) Division of 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of Certificate: 28c. Injury at Hospital or Attending X Natural 5 Pending injury s after death.

I Director: Aft
d in by the fur work' 1 Yes 2 No 2 Accident
3 Suicide Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined completed filled Medical 29a. Certifier 🕱 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated To the within 2 D65643

Registrar DHMH 17 Rev 7/2009 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

M.D.,

Rebecca D. Kaltman,

DEC 24

31. Date filed (Month, Day, Year)

December 22, 2009

6410 Rockledge Dr., Suite 506, Bethesda, MD 20817

			1 - For State Registrar	State of M		epartment of Certificate of	Health and N		giene Reg. No.2009	42952
1	Physic	ion	1. Decedent's Name (First, Middle	, Last)				2. Date of Dea	ath _	3. Time of Death
1	Physic /Medi		Benjamin		nklin	Davis,	Sr.	Month 2	Day Year 200	9 5:30pm
	Exami	ner	4a. Facility Name (If not institution			4b. City, Town,	or Location of Death		4c. County of Dea	
			Coestal Hosp	ice at too		90×	rusten	+	VVice	mico
	Funeral		,	6. Sex 7. Ag	ge (In yrs. last birtho	Months Days		B. Date of Birt (Month, Da		thplace (State or Foreign ountry)
	Director		216-38-7666 Usual Residence of Decedent		67 Yrs			5-11-1	942 Vi	rginia
	yland yland at		10a. State 10b. County		10c. City, Town o	Location				10d. Inside City Limits
	Mar a-f sh	to	MD Wicom	ico	Sali	sbury				1 □Yes 2X No
	or 28,	Director	10e. Street and Number	100	Dall	10f. Zip Code			10g. Citizen of What Co	L
٠	th will	al	32152 Twilley B	ridge Road		2	21804		USA	
2	r dea ems er mi	Funeral I	11. Marital Status	12. Was Decedent Armed Forces?	Ever in U.S.		Hispanic Origin? (Sp. ban, Mexican, Puerto	ecify Yes or No-	14. Race - Ame	
)ayi	or it	by Ft	1 ☐ Never Married 2 🔀 Marri		No	1 ☐ Yes 2 🏋 No		nican, etc.)		e, etc. Thite
$\tilde{\mathcal{A}}$	hours ural"	D D	3 Widowed 4 Divorced	Year or Dates:						
7 5	n 72 r "nal	Completed	15. Decedent (Specify only highes	s Education t grade completed)	16a. De	ecedent's Usual Occu	ipation e during most of worki ed)	ing	16b. Kind of Business/	Industry
. 212	withi iene. thar	E O	Elementary/Secondary (0-12) 7	College (1-4or	0+ <i>)</i>	ner/Operat			Candbahd -	_
C 5	filed I Hyg other ent,	BeC	17. Father's Name (First, Middle, L	ast)	Owi	ier/Operat	18. Mother's Name	(First, Middle,	Sanitatio Maiden Surname)	<u>n</u>
) (Je	should be filed within 72 hours after death with the Maryland and Memal Hygiene. Imarked other than "natural", or items 23a or 28a-f show imatic event, it a Madical Examiner must be notified at	To B	Rov	L.	D:	avis	Nora	Mae	_	dolph
Maryland 21215-0036		-	19a. Informant's Name/Relationsh						er, City or Town, State, 2	dolph Zin Code)
ع م د ،	1 and 2 Health a		Ben Davis, Jr.	- Son					lisbury, MD	
C 5	ges 1 and 2 should be filed within 72 hours after death with the Marylar to f Health and Mental Hygiene. If Item 27 is marked other than "natural", or items 23a or 28a-f show or other traumatic event, the Medical Examiner must be notified at		20a. Method of Disposition		20b. Place of Di	sposition (Name of crematory or other pla			20c. Location - City or	
	Pages nent of ant: If Its ury or o		1 X Burial 2 ☐ Cremation 4 ☐ Donation 5 ☐ Other (Sp				:	0-2009	Salisbury,	Maryland
Baltimore	permit. Pages 1 and 2 Department of Health a Important: If Item 27 is any injury or other tra once.		21. Signature of Fundal Service L	icensete	11	22. Name and Addr			ineral Home	
~ ш	8 Q E 8 9		Tiplissa	Buy 13	Jolpe	705 E. Ma			oury, Maryl	
			23a. Party. Enter the disease, or on shock, or heart failure. List of	complications that caused nly one dause on each li	the death. Do not ne.	enter the mode of dy	ing, such as cardiac o	or respiratory are	rest,	Approximate Interval Between
	Physician		Immediate Cause (Final disease or condition	CARR	BROVAS	CULAR	Accie	1 R NIT	-	Onset and Death
	/Medical Examiner		resulting in death)	Due to (or as	a consequence of):	,				
		<u>.</u>	Sequentially list conditions,	b						
	uter nsi	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlyling Cause (Disease or injury that initiated events	Due to (or as	a consequence of):					
ď	be execute	Exal	that initiated events resulting in death) Last	c Due to (or as	a consequence of):					
8760,	cate be executer physician and the burial-transi	dical		d						
9	rtifica ng phy as th	edi								
Box	eath certific attending p	an/N	IF FEMALE: 23b. Was decedent pregnant	23c. If yes, outcome		200			23d. Date of del	ivery
	deal	Sicie	in the past 12 months? 1 ☐ Yes 2 ☐ No	4 ☐ Pregnant a		3 □ Ectopic pregnan 5 □ Other (spec <i>ify</i>) _	cy 		Month	Day Year
P.0	at the	Physician/Me	9 🗆 Unknown							
Š	ding Physician: The law requires that the death certifith. After this certificate has been signed by the attending prinneral director, page 2 should be detached for use as:	5	Part II. Other significant condition	s contributing to death be	ut not resulting in the	underlying cause giv	ven in Part I.		bacco use contribute to	the cause of death?
o.	requi	ted	·			-		1 □ Ye	es 2 7 No 3 □ Pr	obably 4 🗌 Unknown
Division of Vital Records,	e law has b	Completed						24a. Was a autops		topsy findings available completion of cause of
<u>=</u>	r; The licate ha					4		perforg	med? death? E∐No 1∐Yes	-4.79
<u> </u>	Physician; this certificaral director, p	0	25. Was case referred to medical examiner?	Hospital:	-		26. Place of Death	(Check only on	ne)	
of	Phys rthis ral dii	<u>ا</u>	1 ☐ Yes 2 ☐ No 27. Manner of Death	1 ☐ Inpatie	ent 2 ER/Outpat		4 LI Nursing Hor			city) HOSPICIZ
6	Attending r death. ector: After by the funer	ţ	Natural 5 ☐ Pending	(Month, Day	y, Year)	/ Wor	ryat 'k?]Yes 2 □No	28d. Describe ho	ow injury occurred	
<u>:s</u>	or Attendi after death. Director: A I in by the fu	fica	3 ☐ Suicide 6 ☐ Could no	t be	ury - At home, farm,			29f Location (Ct	treet and Number or Ru	D- to Missister
ĕ	at or a after a line of in b	Certification: To	4 ☐ Homicide determin	ed building, etc	c. (Specify)	on out the control of the control	1	City or Towr	n, State)	rai Houle Number,
	To the Hospital or Attenwithin 24 hours after deatl To the Funeral Director:		29a. Certifier Certifying	Physician: To the best of	of my knowledge, de	ath occurred at the ti	me, date and place, a	and due to the c	ause(s) and manner as	s stated.
	he Ho in 24 he Fu pletel	Medical	(Check onl 2 Medical E	caminer: On the basis of and manner sta	f examination and/or	investigation, in my	opinion, death occurre	ed at the time, d	late and place, and due	to the cause(s)
	To the within To the comple	Σ	29b. Signature and title of certifier			29c. Licens		2	9d. Date signed (Month	ı, Day, Year)
						Do	058410		12/25/	109
	4.11		30. Name and address of person w	no completed cause of de	eath (Item 23a) (Typ	e, Print)	058410	1	, ,	
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+	Sta Registra		31. Date filed (Month EC 29	2009 32. egistra	ars Signatur	sale	,			
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State of Maryland / Department of Health and Mental Hygiene

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		1- For State Registrar		icate of De		, ,	Reg. No.	77 47700
Physic		Decedent's Name (First, Middle,Last)				2. Date of De	ath	3. Time of Death
Medical Exam	ine	Meta Frances Eaton 4a. Facility Name (if not institution, give street and number)		- 1 " 0"		Decembe	er 23, 2009	1407 hrs
		1113 Taney Avenue			ty, Town, or Location lisbury	of Death	4c. County o Wicomic	
Funeral			e (In yrs. last t			er 24Hrs. 8. Date of B		Birthplace (State or
Director		577-54-7280 1 M 2 F F	70		onths Days Hours	Min.	5, 1939	Foreign Washington Country) DC
' any		10a, State 10b. County	10c. City, Tov	vn or Location				10d. Inside City Limits
land f show	5	Md. Wicomico	Sali	sbury				1 X Yes 2 No
Mary - 28a-	Director	10e. Street and Number			Zip Code		10g. Citizen of Wha	at Country?
th the 23a o	<u> </u>	1113 Taney Avenue			1801		USA	
D 21215-0036 should be filed within 72 hours after death with the Maryland and Mental Hygiene. Tis marked other than "natural", or items 23a or 28a-f show natic event, the Medical Examiner must be notified at once.	Funeral	11. Marital Status 1 Never Married 2 Married Armed Forces? 1 Yes 2			edent of Hispanic Orig ecify Cuban, Mexican	gin? (Specify Yes or N , Puerto Rican, etc.)	o- 14. Race - White,	American Indian, Black, etc.
s after ral",	ğ	3 X Widowed 4 Divorced If Yes, Give Year or Dates:			2 X No specify:		Specify:	
2 hour "natu Exan	ted	15. Decedent's Education (Specify only highest grade com Elementary/Secondary (0-12) College (1-4 or 5)			ual Occupation (Give l working life. DO NOT		16b. Kind of Bus	iness/Industry
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21215-0036 und be filed within 7 Mental Hygiene. marked other than	Be	John Kopecky			E1	eanor Camps	sa1	
2 2'should should Me is mg attic e	2	19a, Informant's Name/Relationship (Type, Print)	1	9b. Mailing Addre	ess (Street and Num	ber or Rural Route Nu	mber, City or Town,	State, Zip Code)
md 2 salth a		Michael Eaton, Son	120b Blace	516 Prin	nceton Dr.	, Alexandr		
imore, MD 21215-0036 Pages I and 2 should be filed within 72 hours after men to fleathth and Mental Hygiene fant: If item 27 is marked other than "natural", or other traumatic event, the Medical Examiner.		1 Burial 2 X Cremation 3 Removal from Sta	te crem	atory or other place	ce)	Date		City or Town, State
Security Assistant Educa								ria, Virginia
Bal permi Depa Impo injur		21. Signature of Funeral Salvice Licensee						Chapel , Va. 22315
Physician 23a. Fart I be disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart								
Examiner Immediate Cause (Final disease a. Atherosclerotic cardiovascular disease								
-		or condition resulting in death) Due to (or as a conse	quence of):					
	ē	Sequentially list conditions, if any, leading to immediate b. Due to (or as a conse	quence of);					
	Examiner	cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death). Last	guango of):					
uted nd ransit	Ä	events resulting in death) Last Due to (or as a conse	quence on.					
ision of Vital Records, P.O. Box 68760, Attending Physician: The law requires that the death certificate be executed redeath. reteath. ector: After this certificate has been signed by the attending physician and by the funeral director, page 2 should be detached for use as the burial - transit	Medical	X UNPENDED AMENDED 3a.I	PII.27.	permE. g	899 1/13/	10 тт		
760, ficate be g physica the buri	We	23b. Was decedent progrant in the	e of pregnancy	y			23d. Date of de	alivery
Box 687 e death certific the attending I ed for use as the	Physician	past 12 months?	ime of death	Fetal deat Other (Sp.	_	pregnancy	Month	Day Year
Bo; e deatl the att	hysi	1 Yes 2 No 9 V Unknown 9 Unknown		o other top				
ed by letach		Part II. Other significant conditions contributing to death	but not resulti	ng in the underlyin	ng cause given in Par	t I. 23e. Did to		te to the cause of death?
S, F	Completed by	<u>Calcific aortic annulus</u> ;	cirrh	osis		1 Yes	2 No 3	Probably 4 🗸 Unknown
ords, w requir	Bet					24a. Was autop		re autopsy findings available or to completion of cause of
Rec The la	ĕ					perfor 1 V Yes		ith? Yes 2 No
tal Recian: The certificate	Be	25. Was case referred to medical examiner?			26.Place of Death (Check only one)		
F Vi Physic or this	<u>e</u> L	1 Yes 2 No No Inpatier					Residence 6 🗸	
Division of Vital Records, P.O. Ital or Attending Physician: The law requires that to ra after death. Is Director: After this certificate has been signed by led in by the funeral director, page 2 should be detaced.	ë	27. Manner of Death 1 X Natural 5 Pending 28a. Date of Injur (Month, Day, Ye	y 28b. ar)	Time of Injury	28c. Injury at Work?		now injury occurred	
Atter	icat	2 Accident Investigation 28e Place of Inju	Inv. At home f	form street factor	ry, office building, etc.		Name of the last o	Description of the New York of the City
Div tall or all Dir	Certification:	3 Suicide 6 Could not be determined (Specify)	ry - Acrioine, i	aini, sireet, lactoi	ry, once ballding, etc.	or Town, S		or Rural Route Number, City
Dithe Hospital hin 24 hours at the Funeral mpletely filled		29a. Certifier 1 Certifying Physician: To the best of my	knowledge, de	eath occurred at th	ne time, date and place	e and due to the cause	a(s) and manner as	bateta
Division To the Hospital or Attend within 24 hours after death To the Funeral Director: completely filled in by the	Medical	one) 2 Medical Examiner: On the basis of exam	ination and/or	investigation, in n	ny opinion, death occi	urred at the time, date a	and place, and due	to the cause(s)
F 3 F 5	Ĭ	29b Signature and title of certifier		29	9c. License number		29d. Date signed	(Month, Day, Year)
		Clue 2:			O.C.M.E.		December 24	, 2009
0 8		30. Name and address of person who completed cause of de	,					
0		Ana Rubio MD. Assistant Medical Exami		Penn Street,	Baltimore, MD 2	21201		
Regist	ate rar	31. Date filed (Month, Day, Year) AN 0 8 2010 Server 6.	Signature					

DHMH 17 Rev 1/2001 OCME 2006

OCME

	1	For State Registrar		State of M	arylan		artment of	Health and I f Death	Mental Hy	/giene Reg. No.	2009	42	954	
		1. Decedent's Name	(First, Middle, La	ist)					2. Date of D	eath	.,	3. Time of	Death	
Physician		Fairlie	Stirlino	Evason					Month Decemb	Day Der 22	2 2009	1:00	AM	
/Medica Examine				ve street and number)			4b. City, Town	or Location of Death			County of Death	,		
LAAIIIIIG		1073 Lin	dsav Lan	e			Hager	stown		Was	shington	Count	ZV	
Funeral		5. Social Security Nu	umber 6.	Sex 7. Ag	je (In yrs.	last birthday		r If Under 24 Hrs.	8. Date of B	irth	9. Birth	lace (State o	or Foreign	
Director		310-60-34	31	1□M 2XF	73	Yrs.	Worldis	3 110210 111111	Jan.	7,1936		land		
p.	- +	Usual Residence of			100 0	y, Town or L	enoties				11	0d. Inside C	ity Limits	
show	. 1	10a. State	10b. County	ton County		•							2 No	
8a-f	ပ္က	Maryland		ton County	па	gerst				10a Citi-	zen of What Cour	otru?		
the state of the s		10e. Street and Nun					10f. Zip Code					ito y .		
ath v	÷ 1	1073 Lind	say Lane		Constall	0 140	2174		nooify Voc or N		S.A.	ran Indian		
er de	ğ	11. Marital Status	₩	12. Was Decedent Armed Forces?	•	5. 13	If Yes, specify C	f Hispanic Origin? (S uban, Mexican, Puert	o Rican, etc.)	0-	Black, White,			
or ", or	D L	1 Never Marrie		1 ∐Yes 2 X If Yes, Give Year or Dates:	INO		1 □Yes 2 💆 N	lo Specify:			Specify: Whi	te		
hour tural	9	5 CI Widowed	15. Decedent's E			16a. Dec	edent's Usual Oc	cupation		16b. Kir	nd of Business/In	dustry		
in 72	Completed		ify only highest gr	rade completed)	- -	(Giv	e kind of work do DO NOT use ret	ne during most of wor ired)	rking					
with iene.	Ē	Elementary/Secon	ndary (0-12)	College (1-4or 2	5+)	Addi	ctions C	ounselor		Hea.	alth Department			
Hyg Hyg Sther ent,	Pe C	17. Father's Name ((First, Middle, Las			-		18. Mother's Nar	ne (First, Middi	(First, Middle, Maiden Surname)				
d be ental ked c	<u>0</u>	James Ja	mieson					Catherin	ne Horsk	ourgh	Jamieso	n		
shou nd M mar mat		19a. Informant's Na		(Type. Print)		19b. Ma	ling Address (Stre	eet and Number or Ri						
ulth a 27 is r trau		Don Evas	on-husba	ınd		107.	3 Lindsa	y Lane Hag	erstown	n, MD	21742			
permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Experiment must be notified at once.		20a. Method of Disp		7	20b. F		position (Name of ematory or other p		Date		cation - City or T	own, State		
Page: ent o nt: If y or			XCremation 3 [5 ☐ Other (Spec	☐ Removal from State :ftv)				atory 12-2	23-2009	Smit	thsburg,	Mary]	Land	
nit. F artm ortar injur	H	21. Signature of Fu						dress of Facility Do						
Dep Imp		1/10	11/2/2-	NIL	in			tern BLvd.						
Physician		shock, or hea Immediate Cause (rt/feilure. List onl; (Final	y one cause on e	d the deat ine.	h. Do not e			c or respiratory	arrest,		Approxima Interval Be Onset and	Death	
/Medical Examiner	disease or condition a. Due to (or as a consequence this)											10-11	IONT	
MARIE	ē	Sequentially list con if any, leading to im	nditions, mediate	b. Due to (or as	s a consec	uence of):								
uted insit	盲	Cause (Disease or	injury								53			
n and	if any, leading to immediate cause. Early Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Due to (or as a consequence of):													
e be	dical			_d										
ifficat g phy as the	ed		1000										-	
To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit	Physician/Med	IF FEMALE: 23b. Was deceden in the past 12 1 ☐ Yes 2 9 ☐ Unknown	months?	23c. If yes, outcom 1 Live birth 4 Pregnant 9 Unknown	2 ☐ Feta at time of	al death 3	B ☐ Ectopic pregn Control Con				23d. Date of deli Month	very Day	Year	
hat the	P P			contributing to death	but not res	sulting in the	underlying cause	given in Part I.	23e. Die	d tobacco u	use contribute to	the cause of	death?	
signe be c	þ	, and modern original				3	, ,		1[]Yes 21	□ No 3 □ Pro	bably 4 x	Unknown	
requi	ted								-				a available	
The law ate has boage 2 sh	Completed								24a. Wa au pe 1 □Yes	topsy rformed?	death?	opsy findings ompletion of 2 \Begin{align*} No	cause of	
ian: artifica stor, i	Be	25. Was case refer examiner?	rred to medical					26. Place of De	ath (Check onl	v oge)				
nysic nis ce direc		1 Yes 2	No	Hospital: 1 ☐ Inpa	tient 2] ER/Outpat	ient 3 DOA	Other: 4 Nursing	Home 5 Re	sidence	6 ☐ Other (Spec	cify)		
nding Pt ath. r: After the e funeral	ation:	27. Manner of Deat 1 Natural 2 Accident	th 5 □ Pending investigati	28a. Date of In (Month, D		28b. Time Injur	y \	njury at Work? 1 □Yes 2 □ No	28d. Describ	e how injur	y occurred			
al or Atte	Certification: To	3 ☐ Suicide 4 ☐ Homicide	6 Could not determine	20e. Place of it	njury - At h etc. <i>(Sp</i> ec	ome, farm, ify)	street, factory, offi	се		(Street ar Town, State	nd Number or Ru e)	ral Route Nu	mber,	
e Hospita 24 hours e Funera detely fille	edical C	29a. Certifier (Check only one)	1 Certifying I 2 Medical Ex	Physician: To the bes aminer: On the basis and manners	of examin	owledge, de ation and/o	eath occurred at the investigation, in r	ne time, date and place my opinion, death occ	ce, and due to t curred at the tim	he cause(s ie, date and	s) and manner as d place, and due	stated. to the cause	:(s)	
To th Withir To th comp	Me	29b. Signature and	title of certifier		1		29c. Lic	ense number		29d. Da	ite signed (Month	n, Day, Year)		

Division of Vital Records, P.O. Box 68760,

Baltimore, Maryland 21215-0036

State

rson who completed cause of death (Item 23a) (Type, Print)

			For State Registrar	State of	Maryland / Dep	artment of F rtificate of	lealth and			09 42955
			Decedent's Name (First, Middle,	Last)		Timodio or		2. Date of De	Reg. No.	3. Time of Death
	Physic /Medi		Hennie Mary	Floyd				Dec.		13:17 M
-	Exami		4a. Facility Name (If not institution,	give street and numb	ber)	4b. City, Town, o	r Location of Deat		4c. County of	
40	<i>'</i>		Fort Washingtor	Hospital	L	For	t Washin	gton	Princ	e George's
	Funeral			. Sex 7	. Age (In yrs. last birthday)		If Under 24 Hrs Hours Min.	8. Date of Birt	th (9. Birthplace (State or Foreign Country)
	Director		216-44-8370	1 L W 2123 F	63 Yrs.	morning Buyo		June 20	, 1946	Maryland
	land ow		Usual Residence of Decedent 10a. State 10b. County		10c. City, Town or Lo	ocation				10d. Inside City Limits
	Mary -f sh	ρ	Marvland Prince	George's		T.	77 1			1 ⊠Yes 2 □ No
	with the Maryland a or 28a-f show	Director	10e. Street and Number	George s		10f. Zip Code	ort Wash	ington	10g. Citizen of Wh	at Country?
	h with	a D	7714 Klovstad Dri	lve			0744			•
	72 hours after death with the Maryland natural", or items 23a or 28a-f show dical Exa., i acroust be redified at	Funeral	11. Marital Status	12. Was Decede	ent Ever in U.S. 13.	Was Decedent of H If Yes, specify Cuba		pecify Yes or No	- 14. Race -	d States American Indian,
98	or it		1 ☐ Never Married 2 🛛 Married	1 ☐ Yes 2	XNO	il Yes, specily Cuba 1 □ Yes 2 🖾 No	In, Mexican, Pueri Specify:	to Hican, etc.)		White, etc.
Ö	72 hours "natural", dical Exe	d by	3 ☐ Widowed 4 ☐ Divorced	Year or Date	es:				Specify:	African American
15-	n 72 "nat	Completed	15. Decedent's (Specify only highest of	Education grade completed)	16a. Dece	dent's Usual Occup kind of work done o DO NOT use retired	ation <i>duri</i> n <i>g most of wor</i>	king	16b. Kind of Busi	ness/Industry ·
12	withi iene. thar	I E	Elementary/Secondary (0-12)	College (1-4	01 2+)					•
P	filed Hygi other ent, I	Be C	17. Father's Name (First, Middle, La		Aui	<u>inistrati</u>			Maiden Surname)	civate
<u>lar</u>	ould be Menta narked	To B	James Lee	Purnell,	Sr.		Ηι	ılda Ell	en McCray	7
Maryland 21215-0036	3.2 should be filed within 72 hou th and Mental Hygiene. 7 is marked other than "natura traumatic event, the Medical E	-	19a. Informant's Name/Relationship	(Type. Print)	19b. Maili	ng Address (Street a				rate, Zip Code) 20744
	permit. Pages 1 and 2 should Department of Health and Mer Important: if item 27 is marke any injury or other traumatic once.		Kimberly Chase-	Longus/ D						on, Maryland
Baltimore,	of He of He fiter		20a. Method of Disposition		20b. Place of Dispo	sition (Name of	a)	Date	20c. Location - Ci	
Ē	Page ment ant: i		1 ☑ Burial 2 ☐ Cremation 3 4 ☐ Donation 5 ☐ Other (Spec	□ Removal from Sta cify)	ate Saint Methodi	Paul st Church	Dec 29	ember 2009	Berlin.	Maryland
alt	permit. Depart import any inj once.		21. Signature of Funeral Service Lio	ensee	A 22	2. Name and Address	s of Facility St	ewart F	uneral Ho	ome, Inc.
ш	6 # 2.0 E		MONONA	Alorso.	DD 4	001 Benni	ing Rd. N	WE Wash	ington, I	
			23a. Part . Softer the disease, or co shock, wheart failure. List on	mplications that cau y one cause on eac	sed the death. Do not ent h line.	er the mode of dyin	g, such as cardiad	or respiratory ar	rrest,	Approximate Interval Between
-	Physician		Immediate Cause (Final disease or condition	-a Card	co pa/mora	orne	46			Onset and Death
4	/Medical Examiner		resulting in death)	Due to (or	as a consequence of):	1				
		Ē	Sequentially list conditions,	b. Due lor	as a consequence of:	1				
	uted d insit	Examiner	Sequentially list conditions, if any leading to immediate cause. Enter Underlying Cause (Disease or injury	Due & Joi	as a consequence of					
oʻ.	exection and and and and and and and and and an	Exa	that initiated events resulting in death) Last	c Due to (or	as a consequence of):					
68760,	The law requires that the death certificate be executed are has been signed by the attending physician and bage 2 should be detached for use as the burial-transit	edical		d						
99	rtifica ng ph as th	Med	VE EEMALE.							
Вох	eath certifi attending for use as	an/l	IF FEMALE: 23b. Was decedent pregnant	23c. If yes, outcom		Ectopic pregnancy			23d. Date of	of delivery
О.	e dea the at ed fo	sici	in the past 12 months? 1 ☐ Yes 2 ☑ No		nt at time of death 5	Other (specify)			Month	n Day Year
Р.	uires that the de signed by the d be detached	Physician/M	9 Unknown							
S,	ires the signe I be d	by	Part II. Other significant conditions	contributing to death	h but not resulting in the ui	iderlying cause give	n in Part I.			ute to the cause of death?
Ö	w require been si should b	eted						1 □ Y	′es 2 kg/No 3 l	☐ Probably 4 ☐ Unknown
360	e law has l	Completed						24a. Was a	sy pric	re autopsy findings available or to completion of cause of
<u>=</u>	ician: The certificate his ector, page							perfor 1 □ Yes		ith?]Yes 2 □No
of Vital Records,	sician: certific rector,	Be	25. Was case referred to medical examiner?	Hospital:		Cabo	26. Place of Dea	th (Check only or	ne)	
of	Phys r this ral di	2	1 Yes 2 No 27. Manner of Death	1 ☐ Inpa			4 LI Nursing H		lence 6 Other	(Specify)
Division	or Attending Physician: Ifter death. Director: After this certific. in by the funeral director, i	tion	Natural 5 Pending 2 Accident investigation	(Month,	Day, Year) Injury	28c. Injury Work' M 1 🗀 y	es 2 □No	28d. Describe h	ow injury occurred	
/isi	Atter r dear ctor by the	fica	3 ☐ Suicide 6 ☐ Could not I	oe 200 Bloom of	 Injury - At home, farm, stre		63 2 1110	28f Location /S	Street and Number	or Rural Route Number,
	al or	Certification:	4 ☐ Homicide determined	building,	etc. (Specify)	•		City or Tow	n, State)	or ritiral rioute (variiber,
	ospit hour unera ily fille	g	29a. Certifier (Check only 2 Medical Exa	hysician: To the be	st of my knowledge, death	occurred at the tim	e, date and place	, and due to the o	cause(s) and mann	er as stated.
	To the Hospital or Attendi within 24 hours after death. To the Funeral Director: A completely filled in by the fu	Medical	one)	and manner	s of examination and/or in	estigation, in my op	inion, death occu	rred at the time, o	date and place, and	I due to the cause(s)
	Neith To To To To To To To To To To To To To	2	29b. Signature and title of certifier			29c. License			29d. Date signed (A	Month, Day, Year)
	_			hur	as Albud		0576	32	12/2	1/09
A	5		30. Name and address of person who	completed cause o	f death (Item 23a) (Type, I				7	/ /
	Sta	6	James Mitchell, 31. Date filed (Month, Day, Year)	132-Reni	LI Livingsto	n Koad F	ort Wash	ington,	Md. 207	44
-	Jid		DEC 0 0 2000	A	B A.A. W.					

DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 42956 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ O'Neil Wesbert Gaines Month 2009 December 8:12 a M Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death Prince Georges Southern Maryland Hospital Clinton 5. Social Security Number 6. Sex If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day,) April 29 7. Age (In vrs. last birthday) 9. Birthplace (State or Foreign **Funeral** Days Hours Min. 1 ★ M 2 □ F Director Washington, D. C. 578-72-1359 Usual Residence of Decedent show 10a. State 10b. County notified at 10c. City, Town or Location Director 28a-f Maryland Prince Georges Suitland Yes 2 No 10e. Street and Number J Hygiene. J other than "natural", or items 23a or vent, the Medical Examiner must be r 10f. Zip Code 10g. Citizen of What Country? Funeral 2508 Darel Dr. #202 20746 United States within 72 hours after death Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 12. Was Decedent Ever in U.S. 14. Race - American Indian, Black, White, etc 1 ☐ Never Married 2 ☐ Married þ Yes 2x No Baltimore, Maryland 21215-0036 If Yes, Give Year or Dates 1 Yes 2 No Specify. Black Specify: Completed 3 Widowed 4 Divorced 16a, Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) Maintenance Engineerer Government event, Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Malden Surname) and Mental F permit. Page 1 and 2 should be fi Department of Health and Mental Important, If item 27 is marked any injury or other traumatic ev ၉ Robinson Alfred Lorenzo Mae 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Mable A. Gaines / Wife 2508 Darel DR. #202 Suitland, Md. 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State cemetery, crematory or other place) 1

Burial 2

Cremation 3

Removal from State 12/29/2009 Riverdale Crematory Riverdale, Md. 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service, Name and Address of Eacility Dane vander 15 to Pike/ Forestville, Md. 20747 23a. Part 1 Enter the disease, or compleations that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Priysician/ CAMIA disease or condition Medical resulting in death) Due to (or as a consequence of): **Examiner** Sequentially list conditions, Examine if any, leading to immediate cause. Enter Underlying Cause (Disease or linjury that initiated events Due to (or as a consequence of). the Hospital or Attending Physician; The law requires that the death certificate be executed and resulting in death) Last Due to (or as a consequence of): physician a s the burial-Physician/Medical Division of Vital Records, P.O. Box 68760 attending ph IF FEMALE 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy
5 Other (specify) in the past 12 months? Day Year Pregnant at time of death 2 No 9 Unknown 9 Unknown signed by t Part II. <mark>Other significant conditions</mark> contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown has been sign 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed page 1 ☐ Yes 2 ☐ No Yes 2 ☑ No Be 25. Was care referred to medical 26. Place of Death (Check only one) exammer? Hospital 2 \square No Other: 2 1 Inpatient 2 ER/Outpatient 3 IDOA 4 Nursing Home 5 Residence 6 Other (Specify) After this 28a. Date of injury (Month, Day, Year) 27. Man er of Death 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred Natural 5 Pending injury work? 1 ☐ Yes 2 ☐ No death. Accident Suicide M Investigation within 24 hours after death

To the Funeral Director: α

completed filled in by the 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 28f. Location (Street and Number or Rural Route Number, determined Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check 3 [certifying Nurse Practioner. To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one) Signature and ti 29c, License number 29d. Date signed (Month, Day, Year)

W 3

State Registrar

DHMH 17 Rev 7/2009

30. Name and address of person who completed cause of death (Item 23a), (Type, Print)

32. Registrar's Sign

			1 - For State Registrar AVEND#7perFH				artmen rtificate			and M		Reg. No.	2009	1230						
	Physic	an	Decedent's Name (First, Middle, L	,	-1 7						2. Date of D	Day	Yea	3. Time of Dea						
1	/Medi Examir		Hajieh 4a. Facility Name (If not institution, gr		Ghala	mzan		Town or	Location of	of Death	12-23		County of De	1:00 a	1					
	Examili	iei	14501 Quince C						ersb				ontgo							
	Funeral		Social Security Number 6.	Sex 7. Ag	ge (In yrs. las	t birthday)	If Under Months		If Under		8. Date of Bi	rth	9 F	irthplace (State or For Country)	reign					
	Director		213-92-1715	1 M 20 F	81 82	Yrs.	WORKIS	Days	riouis	(4111).	8-30-	1927	7 I	ran						
	and w		Usual Residence of Decedent 10a. State 10b. County		10c. City, 1	own or Lo	cation	-						10d. Inside City Lin	mits					
	the Marylan r 28a-f ehow notified at	ত্	Md. Monto	omery	G	aith	ersb	urg						1 ∑ Yes 2 □						
	r 28a	rec	10e. Street and Number				10f. Zip	Code				10g. Citiz	zen of What	Country?						
	th with	a D	14501 Quince C	rchard R	d.		2	0870)			Us	sa							
920	hours effer death with the Maryland tural', or items 23s or 28a-f show al Examiner must be notified at	by Funeral Director	11. Marital Status 1 Never Married 2 Married 3 XWidowed 4 Divorced	12. Was Decedent Armed Forces: 1 ☐ Yes 2 ☑ If Yes, Give Year or Dates:	?		Was Deced f Yes, spec 1 ☐ Yes 2		spanic Orig n, Mexican Specify:	gin? (Spe , Puerto	ncify Yes or No Rican, etc.)		14. Race - Ar Black, Wi Specify: W	-						
20	72 ho	ted	15. Decedent's E		1	6a. Deced	dent's Usua	Occupa	tion			16b. Kir	nd of Busines	ss/Industry						
Maryland 21215-0036	d within liene. r than "	Completed	Elementary/Secondary (0-12) 1 2	College (1-4or	5+)		kind of word DO NOT us emake	er					me							
yland	s 1 and 2 should be filed if Heelth and Mental Hyg Item 27 is marked othe other traumatic event,	To Be	17. Father's Name (First, Middle, Las Asghar Ghalam	-					Haba	abeh)	a	·							
Nar	de la sharand la shara		19a. Informant's Name/Relationship											Zip Code) 2087	0					
	of Heelth of Heelth (1) Item 27 I		Ardashir Vedad 20a. Method of Disposition	1- son			1 Qu:		Orc		d Dr,			ourg, Md.						
Baltimore,	Page tent of nt: if ry or		1 Burial 2 ☐ Cremation 3 { 4 ☐ Donation 5 ☐ Other (Special)	ify)	cem	etery, cren i 1 y	natory or oth Ceme i	tery	7 '	2-2	8-09	Esf	ahan,	or Town, State Iran						
Ba	permit. Pa Depertmen Importenti any injury	21. Signature of Funeral Service Licensee 22. Name and Address of Facility 411 Kennedy Universal Mortuary, Washi 23a. Part. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest,										shin	ington, D.C. 20011							
1	Example be executed // Medical whysician and the burial-transit	by Physician/Medical Examiner	dicai Exa	dical Exa	dicai Exa	dicai Exa	dicai Exa	shock, or heart failure. List only Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	Respin Due to (or as Massiv	a consequent a consequent fibr	inf ce of): coke ce of): illu ce of):	ecti	on/	Pne	umo	nia			Approximate Interval Between Onset and Death	
P.O. Box 68	The law requires that the death certificate be executed ate hes been signed by the attending physician and page 2 should be detached for use as the burial-transit											Ectopic pregnancy Other (specify)				23d. Date of delivery Month Day Year				
rds, P	quires that n signed b	d by Pi	Part II. Other significant conditions contributing to death but not resulting in the underlying of Aortic Valve Surgery									obacco us Yes 2 🕽		to the cause of death? Probably 4 Unkno						
		Completed								24a. Was autops perform			sy prior to completion of cause of med? death?							
/ita	Phyeician: this certificatal director, I		25. Was case referred to medical examiner?						26. Place	of Death	1 ☐ Yes (Check only o	2⁄χ No one)								
₹		၉	1 ☐ Yes 2 ☐XNo	Hospital: 1 Inpatie		Outpatient		-	4 LI Nur	sing Hom	ne 5√∑ Resi	dence 6	□Other (Sp	ecify)						
Division o	i or Attending Phater death. Director: After the in by the funeral	Certification;	27. Manner of Death 12 Natural 5 ☐ Pending 2 ☐ Accident investigatio		ry 28t y Year)	b. Time of Injury	м 28	c. Injury Work? 1 🗆 Y	at es 2 □ N		8d. Describe	how injury	occurred							
Divi	pitel or Atten ours after deati leral Director: filled in by the	Certifi	3 Suicide 6 Could not be determined		ury - At home, c. <i>(Specify)</i>	farm, stre	et, factory,	office		2	8f. Location (: City or To	Street and wn, State)	Number or I	Rural Route Number,						
	To the Hospitel or Attending within 24 hours after death. To the Funeral Director: After completely filled in by the funer	Medical	one)	nysician: To the best of miner: On the basis of and manner sta	examination	dge, death and/or inv	occurred at estigation, i	t the time n my <i>o</i> pi	, date and nion, death	place, a occurre	nd due to the d at the time,	cause(s) a date and p	and manner a place, and du	as stated. se to the cause(s)						
	2 € 6 8 7	2	29b. Signature and title of certifier	uyhui 1	Vair	é	1	License 39	32	2			signed (Mor	oth, Day, Year)						
			30. Name and address of person who	empleted cause of d	eath (Item 23a	a) (Type, F	Print)							2090	1					
			Rashid Baghai	Naini,M.	.D. 34	14 U1	niver	sit	y Bl	vd.	#324,	Silv	er Sp							
	Star Registra	C	31. Date filed (Month, Day, Year) DEC 2 4 200	32. Registra	ar's Signature	bar	es.													

DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

amend 1tem 5 per fh 8899 1-21-10 vt 196
State of Maryland / Department of Health and Mental Hygiene 109 42958 State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month рΜ Bessie M. Hicks 2009 Dec 2.00 Medical Examiner 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Washington Adventist Hospital Takoma Park, MD Montgomery 5. Social Security Number **2559** 579–48–2555 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 9. Birthplace (State or Foreign Country) Emporia, VA **Funeral** 8. Date of Birth (Month, Day, Ye Jul. 18, 1 □ M 2 🕽 Hours Min. Director 76 Usual Residence of Decedent 23a or 28a-f shov 10a. State Page 1 and 2 should be filed within 72 hours after death with the Maryland ment of Health and Mental Hygiene. ant. If item 27 is marked other than "natural", or items 23a or 28a-f sho 10b. County 10c. City, Town or Location Examiner must be notified at Director 1 Yes 2 No MDPrince Georges Hyattsville 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? by Funeral 6500 Riggs Road 20783 Prince Georges "natural", or items Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 12. Was Decedent Ever in U.S. 14. Race - American Indian, Armed Forces?

1 Yes 2 X No Black, White, etc. 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No If Yes, Give Specify Completed 3 ₩ Widowed 4 □ Divorced Specify: Year or Dates Black traumatic event, the Medical 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) Private service hostess Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) 2 Paul Myrick Edna Reese 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Renee Parker / Daughter 1305 Iverson Street Apt. 103 Oxon Hill, Md. 20745 other Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) permit. Page 1 a
Department of H
Important: If ite
any injury or ot
once, 20c. Location - City or Town, State Burial 2 ☐ Chemation 3 ☐ Ren 4 ☐ Donation 5 ☐ Other (Specify) val from State FT. Lincoln Cemetary Dec.28, 2009 Bentwood, MD 1. Signature of Puneral Service 22. Name and Address of Facility JOHN T. RHINES FUNERAL HOME LLC 3005 12th Street NE Washington, DC 20017 Part 1. Enter the disease, or completions that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death nmediate Cause (Final LMONA Physician, sease or condition Medical resulting in death) Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury that initiated events Examine Due to (or as a consequence of) signed by the attending physician and dedetached for use as the burial-tran resulting in death) Last Physician/Medical Hospital or Attending Physician: The law requires that the death certificate be 24 hours after death. Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy 5 Other (specify) ____ in the past 12 months?

1 Yes 2 No Month Pregnant at time of death Dav Year 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by cate has been sig , page 2 should b 1 ☐ Yes 2 X No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? 2 🗌 No 1 Yes To the Hospital or Attending Physician: within 24 hours after death.

To the Funeral Director: After this certifica completed filled in by the funeral director, f 25. Was case referred to medica Be 26. Flace of Death (Check only one) examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: မ 1 Inpatient 2 K ER/Outpatient 3 IDOA 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred 5 \square Pending 1 Natural injury 2 Accident
3 Suicide 1 ☐ Yes 2 ☐ No Investigation 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) determined 28f. Location (Street and Number or Rural Route Number, City or Town, State) Medical 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check only one) 29b. Signature and title of certifie 29c. License number 29d. Date signed (Month, Day, Year) 40 DECEMBER 21 2009

State Registrar

DHMH 17 Rev 7/2009

31. Date filed (Month, Day, Year) **DEC 2 9** 2009

GREENEBELT MARY LAND 20-770

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ December 2009 9:30 pm Henry W. Herman Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death <u>3200 N. Leisure World Blvd.,</u>#210 Silver Spring Montgomery Social Security Number Sex 1 ፟ M 2 ☐ F Age (In yrs. last birthdav) Year If Under 24 Hrs. If Under **Funeral** 8 Date of Birth 9. Birthplace (State or Foreign Days Hours Min 0372671995 Director 579-10-9347 94 washington. Usual Residence of Decedent item 27 is marked other than "natural", or items 23a or 28a-f show other traumatic event, the Medical Examiner must be notified at 10a. State 10b. County be filed within 72 hours after death with the Maryland 10c. City. Town or Location Director 10d. Inside City Limits Maryland 1 Yes 2 Y No Montgomery Silver Spring 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Completed by Funeral 3200 N. Leisure World Blvd.. 20906 u.s.A 12. Was Decedent Ever in U.S. 11. Marital Status 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Armed Forces? 1 Never Married 2 X Married Maryland 21215-0036 If Yes Give 1 ☐ Yes 2 X No Specify. 3 Widowed 4 Divorced White. 15. Decedent's Education (Specify only highest grade completed) 16a, Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) and Mental Hygiene. is marked other than " Elementary/Seconday (0-12) College (1-4 or 5+) 5+ Aerospace Engineer Federal Government Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Department of Health and Menta Important: If item 27 is marked any injury or other traumatic and once. Lewis Herman Lorette Baer 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Debbie Diatz - Daughter 24313 Welsh Road, Gaithersburg, Maryland 20882 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place, Date 20c. Location - City or Town, State ▼ Burial 2 □ Cremation 3 □ Removal from State Judean Memorial Gdns. 4 ☐ Donation 5 ☐ Other (Specify) 12/27/2009 Olney, Maryland 22. Name and Address of Facility Hines-Rinaldi Funeral Home, Signature of Funeral Salvio Livensee 11800 New Hampshire Ave., Silver Spring, MD 20904 23a Part 1. Inter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Interval Between Immediate Cause (Final Onset and Death

month Finysician/ disease or condition resulting in death) Pancreatic Cancer Medical Due to (or as a consequence of) Examiner Sequentially list conditions. Examine rany, leading to inmediate cause. Enter Underlying Cause (Disease or iinjury Due to (or as a consequence of). To the Hospital or Attending Physician: The law requires that the death certificate be executed attending physician and for use as the burial-tran that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical Division of Vital Records, P.O. Box 68760 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ____ in the past 12 months?
1 ☐ Yes 2 ☐ No Dav signed by the and be detached f 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? by Diabetes Mellitus Completed 1 ☐ Yes 2 🗶 No 3 ☐ Probably 4 ☐ Unknown 24a. Was an Were autopsy findings available prior to completion of cause of cate has page 2 s autopsy performed?

Yes 2 X No certificate 1 🗌 Yes 2 🗆 No 25. Was case referred to medical Certificate: To Be 26. Place of Death (Check only one) 1 ☐ Yes 2 🕱 No Other: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA within 24 hours after death.

To the Funeral Director: After this completed filled in by the funeral dir 4 ☐ Nursing Home 5 🗓 Residence 6 ☐ Other (Specify) 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at work? 1 ☐ Yes 2 ☐ No 28d. Describe how injury occurred 1 X Natural . .atural ☐ Accident ☐ Suic 5 Pending Investigation 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 28f. Location (Street and Number or Rural Route Number, Medical 🗓 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a, Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated (Check 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

State Registrar DHMH 17 Rev 7/2009 29b. Signature and title of certifier

James A. Rossi.

DEC 24

31. Date filed (Month, Day, Year

Ana aroni

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

M.D.

Registrar's Signat

29c. License number

D24543

3305 N. Leisure World Blvd., Silver Spring, Maryland 20906

December 22. 2009

			1- State of Maryland / Dep State of Maryland / Dep Registrar Amend Item 25 per dr., 9899.0	artment of Health and N 1/12/10dhb ortificate of Death	Mental Hygie	ene 1. No. 2009 42960						
	Physici /Medic		1. Decedent's Name (First, Middle, Last) Dwight Wayne Hollingsworth		2. Date of Death Month December	Day Year 09:30 AM						
and a	Examir		4a. Facility Name (If not institution, give street and number) 14020 Mill Village Dr.	4b. City, Town, or Location of Death Maugansville		4c. County of Death Washington						
ı	Funeral Director		5. Social Security Number 219-44-3686 Usual Residence of Decedent 6. Sex 1 M 2 F 7. Age (In yrs. last birthday 6.1 Yrs.	Months Days Hours Min.	8. Date of Birth (Month, Day, Young) Jan . 1 , 1							
e Maryland Sa-f show liftind 21		Director	10a. State 10b. County 10c. City, Town or L Md. Washington Maugar	nsville		10d. Inside City Limits 1 ☐ Yes 2 🔯 No						
th with th	ath with the 23a or 2	ral Dire	10e. Street and Number 14020 Mill Village Dr.	10f. Zip Code 21767	10g	g. Citizen of What Country? $U \cdot S \cdot A$						
5-0036	J within 72 hours after death with the Maryland glene. I than "natural", or items 23a or 28a-f show the live feet be notified at	by Funeral	11. Marital Status 1 □ Never Married 2 □ Married 3 □ Widowed 4 □ Divorced 12. Was Decedent Ever in U.S. Armed Forces? 1½□ Yes 2 □ No If Yes, Give Year or Dates:	Was Decedent of Hispanic Origin? (Sp. If Yes, specify Cuban, Mexican, Puerto 1 ☐ Yes 2 ☐ No Specify:	pecify Yes or No- p Rican, <i>e</i> tc.)	14. Race - American Indian, Black, White, etc. Specify: White						
0-6121	within 72 ho ene. than "natur	Completed	(Specify only highest grade completed) (Give Elementary/Secondary (0-12) College (1-4or 5+)	edent's Usual Occupation e kind of work done during most of work DO NOT use retired) Stocker	king	b. Kind of Business/Industry Grocery						
land 2	othe ent,	To Be Co	12 17. Father's Name (First, Middle, Last) Walter Richard Hollingsworth		e (First, Middle, Mai A . Rodger,	iden Surname)						
, mary	and 2 should be salth and Mental 127 Is marked er traumatic ev	-	19a. Informant's Name/Relationship (Type. Print) 19b. Mail	ing Address (Street and Number or Rui	ral Route Number, C	City or Town, State, Zip Code)						
Imore	permit. Pages 1 and 2 should be Department of Health and Menta Important: If item 27 Is marked any Injury or other traumatic evonce.			osition (Name of matory or other place) To Crematory 20	30,	c. Location - City or Town, State Smi thsburg, Md.						
Dall	Departition Depart		Jeller Javis MO1414	2. Name and Address of Facility J.L. Davis Funeral	Home Smi							
	Physician /Medical Examiner	1	23a. Part 1. Enter the disease, or complications that caused the death. Do not en shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) a. Due to (or as a consequence of):	iter the mode of dying, such as cardiac		Interval Between						
		edical Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Inderlying Cause (Disease or injury that initiated events resulting in death) Last b. Due to (or as a consequence of). c. Due to (or as a consequence of):									
O. DOX 00	± 00 %	Physician/Med		☐ Ectopic pregnancy ☐ Other (specify)		23d. Date of delivery Month Day Year						
r (spins)	equires that en signed b	by	23e. Did topacco use contribute to the cause of deal									
יי הפכר	cate has be page 2 sho	Completed	ATRIAL FIBRILLIATION 24a. Was an autopsy findings averaged performed? DIABFTES MELLITUS TYPE II 24b. Were autopsy findings averaged performed? 24b. Were autopsy findings averaged performed? 24b. Were autopsy findings averaged performed? 25cm 25cm 25cm 25cm 25cm 25cm 25cm 25cm									
Ž :	certifi ector	Be	25. Was case referred to medical examiner?		h (Check only one)							
5	Ing rnys After this uneral dir	on: To	1 Yes 2 No No No Note in the Inpatient 2 ER/Outpatient 3 DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify)									
DISIAIS	after death Director: , J in by the f	Certification:	2 Accident investigation M 1 Yes 2 No 3 Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office 28f. Location (Street and Number or Rural Route Number of Town, State) 28f. Location (Street and Number or Rural Route Number of Town, State) 28f. Location (Street and Number or Rural Route Number of Town, State) 28f. Location (Street and Number or Rural Route Number of Town, State) 28f. Location (Street and Number of Rural Route Number of Town, State) 28f. Location (Street and Number of Rural Route Number of Town, State) 28f. Location (Street and Number of Rural Route Number of Town, State) 28f. Location (Street and Number of Rural Route Number of Town, State) 28f. Location (Street and Number of Rural Route Number of Town, State) 28f. Location (Street and Number of Rural Route Number of Town, State) 28f. Location (Street and Number of Rural Route Number of Town, State) 28f. Location (Street and Number of									
	e nospita 24 hours e Funeral	Medical C	29a. Certifier (Check only one) Certifying Physician: To the best of my knowledge, deal 2 Medical Examiner: On the basis of examination and/or in and manner stated.	h occurred at the time, date and place, ivestigation, in my opinion, death occur	and due to the caus red at the time, date	se(s) and manner as stated. and place, and due to the cause(s)						
į	vithir To th	Me	29b. Signature and life of certifier	29c. License number	29d.	Date signed (Month, Day, Year)						
			report no.	0058181	Dec	CEMBER 29, 2009						
	8		30. Name and address of person who completed cause of death (Item 23a) (Type, KC) LAST FERSTH 324 E. ANTIETH	Print) Print) H ST& # 306 HAU	GERSTONA	1 MD 21740 .						
	Stat Registra	te ar	30. Name and address of person who completed cause of death (Item 23a) (Type, KC) LUST FERSTH 32 FE PARTETH 31. Date filled (Month, Day, Year) 22. Registrar's Signature	Rod	, -	- W. 1, 10						

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State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician Day JORDAN **BRENDA** 4:15 P /Medical 22 2009 DECRMBER 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner PRINCE GEORGE'S CHEVERLY PRINCE GEORGE'S HOSPITAL If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, FEB 5 5. Social Security Number 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign **Funeral** Hours 1 □ M 2 🗓 F Months Days 1940 WASHINGTON, DC 69 Director 577-54-4969 Usual Residence of Decedent with the Maryland 10a. State 10d. Inside City Limits 10b. County 10c. City, Town or Location 28a-f show th and Mental Hygiene. 7 is marked other than "natural", or items 23a or 28a-f shov traumatic event, the Medical Exemit or must be retified at Director Yes 2□No WASHINGTON DC 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 20003 USA 1843 MASSACHUSETTS AVENUE S.E. death v Funeral Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14 Bace - American Indian 11. Marital Status filed within 72 hours after 1 Never Married 2 Married Baltimore, Maryland 21215-0036 Specify: BLACK 1 ☐ Yes 2 X No Specify þ 3 Widowed 4 Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) GOVERNMENT YRS SECRETARY 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be CHARLES ANDERSON **ALMA** SMITH ပ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit, Pages 1 and 2 s
Department of Health as
Important; If item 27 is
any injury or other trau 1843 MASSACHUSETTS AVENUE S.E. WASHINGTON, DC 20003 THOMAS N. JORDAN - Husband 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 1 □xBurial 2 □ Cremation 3 Removal from State RESURRECTION CEMETERY 12/30/09 CLINTON, MARYLAND 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility Signation of Fundal Service L J. B. JENKINS FUNERAL HOME - 5 7474 LANDOVER ROAD LANDOVER, MARYLAND 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** ANOXIC ENCEPHALOPATHY /Medical Due to (or as a consequence of) **Examiner** CARDIAC ARREST Sequentially list conditions, if any, reading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examine Due to for as a consequence off death certificate be executed burial-transi CORONARY ARTERY DISEASE Due to (or as a consequence of): O. Box 68760, ending physician use as the burial Physician/Medical the attending part of for use as t IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant in the past 12 months? 23d. Date of delivery 1 Live birth 2 Fetal dea 4 Pregnant at time of death 3 Ectopic pregnancy Month Day Year 1 ☐ Yes 2 🔀 No 5 Other (specify) 9 Unknown signed by the 9 Unknown σ. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? of Vital Records, \$ 3 ☐ Probably 4 ∑ Unknown 1 ☐ Yes 2 ☐ No Completed peen 24b. Were autopsy findings available prior to completion of cause of death?
1 □Yes 2 ▼No 24a. Was an page 2 s certificate 1 ☐ Yes 2 😾 No 2**√** No 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 📉 No 1 Nopatient 2 ☐ ER/Outpatient 3 ☐ DOA 28a. Date of Injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28d. Describe how injury occurred After Certification: Division or Attending 1 📉 Natural 5 Pending investigation within 24 hours after death.

To the Funeral Director: A completely filled in by the fu death. 1 ☐ Yes 2 ☐ No 2 Accident 3 Suicide 6 ☐ Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a, Certifier Medical and manner stated 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) D0067810 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) AMBREEN SIDDIQUE M.D. 3001 HOSPITAL DRIVE CHEVERLY, MARYLAND 20785 31. Date filed (Month State DEC 2 9 2009

Registrar

State
RegistrarAmended item#5, WCHD, SU, 12. 1. Decedent's Name (First, Middle, Last) Day Physician/ 14:55 PM Gary M. Johnson 2009 Medical Facility Name (if not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death Examiner HICOMICO 50/15611 If Under 1 Year | If Under 24 Hrs. 7. Age (In yrs. last birthday) 8. Date of Birth NY Country) 9. Birthplace (State or Foreign **Funeral** 1 🛛 M 2 🗆 F Months Davs Hours Min. (Month, Day, Year Director Usual Residence of Decedent show or 28a-f shov notified at 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits within 72 hours after death with the Maryland Director MD 1 Yes 2 XNo Upper Hill Somerset 10e. Street and Numbe 10f. Zip Code 10g. Citizen of What Country? ō "natural", or items 23a or Funeral 21867 27770 Waters Lane U.S.A. 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-14 Race - American Indian 11. Marital Status Armed Forces?

1 Yes 2 XNo Yes, specify Cuban, Mexican, Puerto Rican, etc. Black, White, etc. 1 Never Married 2 X Married þ Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ▼ No Specify: If Yes, Give Year or Dates Specify: Black 3 Divorced 4 Divorced Completed the Medical 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b, Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) of Health and Mental Hygiene. Item 27 is marked other than other traumatic event, the Me Elementary/Seconday (0-12) College (1-4 or 5+) Sam's Club months Supervisor Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ပ Barbara Johnson Obie Snead 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Page 1 and 2 sh Department of Health ar Important: If item 27 is any injury or other trau 27770 Waters Lane, Upper Hill, MD 21867 Chrindia Johnson/Wife 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date 1 Burial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify) cemetery, crematory or other place) Handy Family Cem 12/26/2009 Upper Hill, MD 22. Name and Address of Facility 917 W. Isabella St. 21. Signature of Funeral Service Licensee Bennie Smith Salisbury. 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Enysician/ ardiae disease or condition Medical resulting in death) Examiner Sequentially list conditions, Examine rany, leading to immediate cause. Enter Underlying Cause (Disease or linjury Due to lor as a c Decapiti Ulcer. attending physician and for use as the burial-transit Hospital or Attending Physician: The law requires that the death certificate be executed that initiated events Due to (or as a cor sequence of resulting in death) Last Physician/Medical Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ in the past 12 months? Year Month Day Pregnant at time of death 2 🗌 No 1 ☐ Yes 2 ☐ Unknown s been signed by the should be detached Unknown P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Records, 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an page 2 has autopsy 1 Yes 2 No this certificate Yes After this certifications funeral director, p 25. Was case referred to medical examiner? Division of Vital 26. Place of Death (Check only one) Be Hospital 2 No 1 🗌 Yes မ 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☑ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at Certificate: 28d. Describe how injury occurred 1 Natural 5 Pending iniury work? 1 ☐ Yes 2 ☐ No within 24 hours after death.

To the Funeral Director: Af completed filled in by the fu М 2 Accident
3 Suicide
4 Homicide Investigation 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, determined City or Town, State) Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated

Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated only one) 29b. Signature and title of certifie -20050 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Registrar

State

Registrar's Signature

		_1	For State Registrar		State of IV	iaryiani	•	tificate of E		and Me	папту	Reg. No			
	Physicia	n/	1. Decedent's Name		, Last)					2	Date of De		ay Year	- 1	Time of Death
	Medic		Robert		Johnson			*			12	2.	3 04		1720 M
	Examin	er			give street and number)	L Jedin	71 C-01	4b. City, Town, or		of Death SOU	ru	1 4c	Vican		٥
	Funeral		5. Social Security N		6. Sex J 7. A	ge (In yrs. la		If Under 1 Year	If Under Hours	24 Hrs. 8	Date of Bir		9. B	irthplace (State or Foreign
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	nd how at	٦	Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location									_		10d. In	nside City Limits
	faryla Ba-f s tified	ecto	DE	Suss	sex	Mi	1ton							1	☐ Yes 2 🔀 No
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	h with	Funeral Director	29218 S	tockley				1996		- 1- 0 /D i4	. Von av Na	_	USA		dt
036	1 and 2 should be filed within 72 hours after death with the Maryland if Health and Mental Hygiene. item 27 is marked other than "natural", or items 23a or 28a-f show item 27 is marked other than "hatural", or items 23a or 28a-f show other traumatic event, the Medical Examiner must be notified at	Completed by Fu	11. Marital Status1 Never Marr3 Widowed		If Vac Give	?		Vas Decedent of Hi f Yes, specify Cuba			an, etc.)		14. Race - Am Black, Wh Specify: W	ite, etc.	
21215-0036	72 hour r'natu	plet	(Spe		nt's Education est grade completed)		(Give I	lent's Usual Occup kind of work done of NOT use retired)		et of working		16b. I	Kind of Busines	s Industry	1
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br	should be filed within and Mental Hygiene. is marked other tha 'aumatic event, the f	Be	17. Father's Name	First, Middle, I	Last)			·	18. Moth	ner's Name (F	irst, Middle	, Maider	Surname)		
ylaı	Menta	욘	James P							lith I		_			
Maryland	2 shou th and 27 is rr traum		19a. Informant's N						ddress (Street and Number or Rural Route Numbe Black Marlin Circle, Le						
	and 2 s Health tem 27 other tra		John D. 20a. Method of Dis	position			lace of Dispo	sition (Name of		Dat			Location - City		State
ШŌ	Page 1 nent of ant: If it ury or o		1 ☐ Burial 2 4 ☐ Donation	Cremation 5 Other (\$	3 ☐ Removal from Stat Specify)	e Eas	tern S	hatory or other place hore natorium		12/27	/2009	Le	wes, De	1awa	re
Baltimore,	permit, Page 1 and 2 & Department of Health Important: If item 27 any injury or other trooner.		21. Signature of Fu	neral Service I	Licensee all	el	22	Name and Address Parsell 16961 Ki						958	
			shock, or hea	art failure. List	r complications that caus only one cause on each li	ne.	n. Do not ente	er the mode of dyin	g, such as	cardiac or r	espiratory a	rrest,		Inter	oroximate rval Between set and Death
	Physician/ Medical		Immediate Cause disease or condition resulting in death)	(Final on	a. Subc	harm	heur	atur						6	days
Т	Examiner					« \ \	ierice oij.								·1
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	cuted ind transit	xam	that initiated even	ts 'injury	c. Due to (or a	e a consequ	ience of).		··					+-	
_	icate be executed physician and s the bural-transi	ledical Examiner	resulting in death)	Last	bue to (or a	s a consequ	ionoc oij.								
209	icate t physis the l				d							- 1			
Box 68	e death certificate be executed the attending physician and hed for use as the bunal-transit	Completed by Physician/N	IF FEMALE: 23b. Was deceden in the past 12 1 ☐ Yes 2 9 ☐ Unknown	months?	23c. If yes, outcom 1 Live Birth 4 Pregnant g Unknown	n 2 ☐ Feta at time of c	Fetal death 3 Ectopic pregnancy						23d. Date of delivery Month Day Year		
P.O.	requires that the de been signed by the should be detached	y Ph	Part II. Other signi	ificant conditi	ons contributing to death	but not res	ulting in the u	ınderlying cause gi	ven in Part	t I.	23e. Did	tobacco	use contribute	to the ca	use of death?
	puires i an sign	ed b	CAD								1 🗆	Yes :	2 ¥ No 3 □	Probably	4 🗌 Unknown
Division of Vital Records,	2 38	omplet	Dm HLS								24a. Was auto per 1 \(\sum \) Yes	opsv	prior t	o comple	indings available tion of cause of
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n of	ding P h. After t funera	ate	27. Manner of Dea	5 🗌 Pendi		Day, Year)	28b. Time o injury	wor	yat k? IYes 2. ∑		d. Describe Srowd		ury occurred		
sion	l or Attending after death. Director: After I in by the fune	Certificate:	2 Accident 3 Suicide 4 Homicide	6 🗌 Could	28e. Place of I	njury - At ho	ome, farm, str	eet, factory, office	100 2		f. Location	(Street a	and Number or	Rural Rou	te Number,
Divi	s after al Dire		4 🗆 Homicide	deteri	hore	etc. (Specify	"			2	City or To	5 to	ckley R	a mi	30 noth
	To the Hospital or Attending Physician: The k within 24 hours after death. To the Funeral Director: After this certificate h completed filled in by the funeral director, page	Medical	(Check	2 Medical	g Physician: To the best Examiner: On the basis o	f examination	n and/or inves	tigation, in my opini	on, death of	occurred at the	ne time, date	and place	ce, and due to th	ne cause(s) and manner stated
	To the within 2 To the comple	Ž	only one) 29b. Signature and		g Nurse Practioner: To the	ne best of m	y knowledge,	29c, Licens			and due to		e(s) and manner Date signed (Mo		Year)
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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ 2/38PM King 2009 Jerome Lee Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Peninsula Pegional Medical conta 11 comic 8. Date of Birth (Month, Day, Year) 07/12/1942 If Under 1 Year If Under 24 Hrs. Birthplace (State or Foreign Country) **Funeral** Days 1 X M 2 □ F 212-40-8542 67 Director Maryland Usual Residence of Decedent or items 23a or 28a-f shov permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f shon any injury or other traumatic event, the Medical Examiner must be notified at 10b. County 10c. City, Town or Location 10d, Inside City Limits 10a. State Director 1 🗌 Yes 2 🔀 No Maryland Wicomico Salisbury 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral USA 26971 Pratt Road 21801 12. Was Decedent Ever in U.S.
Armed Forces?

1 🛣 Yes 2 🗌 No
If Yes, Give National
Year or Dates Guard Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 Never Married 2 X Married Completed by Baltimore, Maryland 21215-0036 ☐ Yes 2 X No Specify. Specify: 3 Widowed 4 Divorced white 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) C & P Telephone Co. technician Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ၉ Norval King Madeline Hastings 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 26971 Pratt Rd., Salisbury, MD 21801 Ann C. King/spouse 20a Method of Disposition 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) 1 D Burial 2 X Cremation 3 Removal from State Salisbury Crematory 12/29/09 Salisbury, MD 4 ☐ Donation 5 ☐ Other (Specify) A C Holloway Funeral Home Professional Association 501 Snow Hill Rd., Salisbury, MD 21804 com. 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician disease or condition resulting in death) Cornary arrany difease Medical Due to (or as a conse uence of) Examiner veumantar Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Examine Due to (or as a consequence of) Hospital or Attending Physician: The law requires that the death certificate be executed signed by the attending physician and defeached for use as the burial-transit that initiated events Due to (or as a consequence of): resulting in death) Last Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy 1 Live Birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ____ in the past 12 months? Month Day Year Pregnant at time of death Yes 2 ☐ No 9 Unknown Part II, Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 Yes 2 No 3 Probably 4 Unknown page 2 should been 24b. Were autopsy findings available 24a. Was an prior to completion of cause of death? After this certificate has autopsy performed? Yes 2 No To the Hospina.
within 24 hours after deatr.
To the Funeral Director. After this certifica...
---maleted filled in by the funeral director, pag. 1 ☐ Yes 2 ☐ No 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 1 No ၉ 1 Inpatient 2 FR/Outpatient 3 I DOA 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at work? 28d. Describe how injury occurred Certificate: 5 \square Pending 1 Natural 1 ☐ Yes 2 ☐ No Investigation 6 Could not be Accident Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certifier 29c. License number 29d, Date signed (Month, Day, Year) 068222 12/25/69 Karen 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 16 m

Registrar DHMH 17 Rev 7/2009

State

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rar's Signature

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31. Date filed (Month, Day, Year)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Month 12009 3:58PM Doris Dana Levy Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death Examiner Doctor's Hospital Prince George's Lanham Social Security Number If Under 1 Year If Under 24 Hrs 8. Date of Birth 9. Birthplace (State or Foreign 7. Age (In yrs. last birthday) **Funeral** Days 1 □ M 2 🗓 F Min Months 0974077922 Washington. DC Yrs Director <u>577-26-</u>5955 87 Usual Residence of Decedent 23a or 28a-f shov 10a, State 10b. County 10c. City, Town or Location 10d. Inside City Limits the Maryland the Medical Examiner must be notified at Director 1 Yes 2 X No Glenn Dale Maryland Prince George's 10f. Zip Code 10g. Citizen of What Country? Completed by Funeral filed within 72 hours after death with U.S.A. 6002 King Arthur Way 20769 or items Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 11. Marital Status 14. Race - American Indian. Armed Forces?

1 Yes 2 X No Black, White, etc. 1 Never Married 2 Married 21215-0036 1 ☐ Yes 2 🛛 No Specify: If Yes, Give 3 X Widowed 4 Divorced Caucasian Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) al Hygiene. Elementary/Seconday (0-12) College (1-4 or 5+) Housewife Own Home 12 Be other traumatic event, Maryland 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) : Page 1 and 2 should be filed tment of Health and Mental H tant: If item 27 is marked ot Dana Acton Estep Thelma Viola Anders 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 5300 Holmes Run Pkwy., #714. Alexandria, VA 22304 John Dana Levy - Son Baltimore, 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a, Method of Disposition 20c. Location - City or Town, State permit. Page 1 a Department of H Important: If ite any injury or ot 1 🗓 Burial 2 🗆 Cremation 3 🗆 Removal from State 4 Denation 5 Other (Specify) Cedar Hill Cemetery 12/28/2009 Suitland, Maryland of 22. Name and Address of Facility Hines-Rinaldi Funeral Home, Inc. Sign A Servic 11800 New Hampshire Ave., Silver Spring, MD 20904 Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between Onset and Death shock or heart failure. List only one cause on each line Gastrointestina Immediate Cause (Final disease or condition resulting in death) Physician. Medical INUK Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Examiner burial-transit To the Hospital or Attending Physician: The law requires that the death certificate be execute within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completed filled in by the funeral director, page 2 should be detached for use as the burial-tran Due to (or as a consequence of): resulting in death) Last Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregna 5 Other (specify) Ectopic pregnancy in the past 12 months?
1 Yes 2 No
9 Unknown Month Day Year Pregnant at time of death 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Be Completed by 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed 1 ☐ Yes 2 ☐ No Yes 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Hospital Other: 2 No မ 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 4 \square Nursing Home 5 \square Residence 6 \square Other (Specify, 27. Manner of Death 28a. Date of injury 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred (Month, Day, Year) injury work? 1 ☐ Yes 2 ☐ No 1 Natural 5 Pending M Accident Investigation Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office 4 Homicide 28f. Location (Street and Number or Rural Route Number, determined building, etc. (Specify) Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 3 🗆 Certifying Nurse Practioner. To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one) 29b. Signature and title of certifier 29d. Date signed (Month, 58213 tougheel! Completed cause of death (Item 23a) (Type, Print) Aunapolis.

DHMH 17 Rev 7/2009

State

Registrar

FARHAD JAMALI

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31. Date filed (Month, Day, Year)

			For State Registrar	State of Mary	yland / Dep $\it C\epsilon$	artment of H ertificate of L	lealth and Ment D <i>eath</i>	tal Hygien Reg. N	1e 2009	42966
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	/Medic Examin Funeral Director		218-20-4411	e at the l	ake In yrs. last birthday Yrs.	Salisi	Hours Min. (A	T .	ur) Coun	olace (State or Foreign
	ryland	_	Usual Residence of Decedent 10a. State 10b. County	1	0c. City, Town or L				1	0d. Inside City Limits
	the Ma 28a-f s	Director	Maryland Wicomi 10e. Street and Number	co	Salisbu	10f. Zip Code		10g (Citizen of What Coun	1 ☐ Yes 2 X No
	tth with 23a or unt be	ral Di	31890 Old Ocean	City Road		21804		109.	USA	
MOYP 215-0036	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, it is Medical Evention in the inoliting at once.	by Funeral	11. Marital Status 1 □ Never Married 2 ▼ Married 3 □ Widowed 4 □ Divorced	12. Was Decedent Eve Armed Forces? 1 □ Yes 2 ▼No If Yes, Give Year or Dates:	er in U.S. 13.	Was Decedent of Hi If Yes, specify Cuba 1 □Yes 2 ☑ No	spanic Origin? (Specify \n, Mexican, Puerto Rican Specify:	res or No- i, etc.)	14. Race - Americ Black, White, e	etc.
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$(\mathcal{F}, \mathcal{L}_{\mathcal{A}})$	uld be file Aental Hy rked oth tic event	To Be	17. Father's Name (First, Middle, Last Noah J. Collins)			18. Mother's Name (First Della M.		en Surname)	
	and 2 should eath and Men n 27 Is marke ter traumatic		19a. Informant's Name/Relationship (James A. Larmor		19b. Mail 3173	ing Address (Street 2 39 Old Oce	and Number or Rural Roue an City Rd.	ite Number, City , Salis	y or Town, State, Zip bury, MD	21804
R_{κ} th Baltimore,	Pages 1 and the part of He ant: If item ury or other		20a. Method of Disposition 1 ☑ Burial 2 ☐ Cremation 3 ☐ 4 ☐ Donation 5 ☐ Other (Specia	Removal from State	20b. Place of Disp cemetery, cre Wicomico Park	osition (Name of ematory or other place Memorial	Date 12/29/0		Location - City or To	
Balt	permit. Departr Importa any Inju	1	Park H	Dompson	i	2. Name and Address Holloway F	s of Facility Uneral Home Ill Rd., Sa	Profes	sional As	sociation
4	Physician /Medical		23a. Part1. Enter the disease, or comshock, or heart failure. List only Immediate Cause (Final disease or condition resulting in death)	plications that caused the one cause on each line.	e death. Do not er	nter the mode of dyin			7 110 2100	Approximate Interval Between Onset and Death
	and I-transit	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last	b						
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Division of Vital Records,	sician: The law requires that the de certificate has been signed by the rector, page 2 should be detached	Completed			•			24a. Was an autopsy performed2 □Yes	prior to cor death?	psy findings available mpletion of cause of
VIIt	ysician s certifi director	o Be	25. Was case referred to medical examiner? 1 ☐ Yes 2 ☑ ⊀o	Hospital:	2 ☐ ER/Outpatie	ent 3 DOA Othe	26. Place of Death (Che		6 Pothar (Casail	HALDIG-
n of	ilng Phy After thi uneral c	ion: To	27. Manner of Death 1 Natural 5 ☐ Pending	28a. Date of Injury (Month, Day, Ye	28b. Time	of 28c. Injury Work	/ at 28d. [Describe how inj		n 1 1 OSPICE
Divisio	To the Hospital or Attending Physician: within 42 hours after death. Of the Funeral Director: After this certification the Funeral director, prompletely filled in by the funeral director, p.	Certification:	2	e 290 Place of Injune	- At home, farm, st Specify)		/es 2 □ No 28f. L	ocation (Street :	and Number or Rura ate)	ul Route Number,
_	Hospital 24 hours Funeral etely filled	Medical C	29a. Certifier (Check only one) Certifying Pt	nysician: To the best of m miner: On the basis of ex and manner stated	amination and/or i	th occurred at the tin nvestigation, in my o	ne, date and place, and d pinion, death occurred at	lue to the cause the time, date a	(s) and manner as s and place, and due to	stated. the cause(s)
	To the within To the compl	Me	29b. Signature and title of certifier			29c. License	number	29d. D	Date signed (Month,	Day, Year)
0	2 400		1/8			Do	058410		2/25/0	9
-	クIVII		30. Name and address of person who	completed cause of death	n (Item 23a) (Type	Print) 3 SAUS	Bucy	nus	21802	Ba.
	Sta Registr		31. Date filed (Month, Day, Year) DEC 29 21	32 Registrar's	Signatur.	ark	,			

DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month Day 49 Ernest Miller Dec 2009 Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Prince George's Southern Maryland Hospital <u>Clinton</u> 8. Date of Birth (Month, Day, Year) Nov. 3, 1930 . Age (In yrs. last birthday, 9. Birthplace (State or Foreign **Funeral** 1 🕱 M 2 🗆 F Months Days Hours Min. South Carolina Director 79 248-44-9000 Nov. Usual Residence of Decedent If item 27 is marked other than "natural", or items 23a or 28a-f show or other traumatic event, the Medical Examiner must be notified at 10b. County 10c. City, Town or Location 10d. Inside City Limits should be filed within 72 hours after death with the Maryland Director 1 X Yes 2 ☐ No Maryland Prince George's Seat Pleasant 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Completed by Funeral 6414 Greig St. Apt. 201 20743 United States Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 12. Was Decedent Ever in U.S. 14. Race - American Indian Armed Forces Black, White, etc. 1 Never Married 2 Married 1 ☐ Yes If Yes, Give 2 X No Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify. **Black** Specify: 3 Divorced Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) id Mental Hygiene. marked other than Elementary/Seconday (0-12) College (1-4 or 5+) Meter Reader Government Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ည Wesley Miller un-ava and I 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) item 27 Page 1 and 2 Shirley A. Grice/ Daughter 10769 Kitchener Court Mitchellville, MD 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State permit. Page 1 a
Department of I
Important: If ite
any injury or ot December Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 28, 2009 Clinton, Maryland Resurrection Simple of Euperal Service Licenses 22. Name and Address of Facility Stewart Funeral Home, 20019 NE Washington, DC Benning Rd. 23a. Part Inter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest Approximate shock, or heart failure. List only one cause on ea Immediate Cause (Final Physician, disease or condition resulting in death) Medical Examiner Sequentially list conditions. Examine if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Due to (or as a consequence of) or Attending Physician: The law requires that the death certificate be executed sate has been signed by the attending physician and page 2 should be detached for use as the burial-tran that initiated events Due to (or as a consequence of): resulting in death) Last Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ in the past 12 months? Month Year 2 🗌 No 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by neumo ni g 2 No 3 □ Probably 4 □ Unknown 1 🗌 Yes 24b. Were autopsy findings available prior to completion of cause of 24a. Was an To the Funeral Director: After this certificate has completed filled in by the funeral director, page 2 s autops, performed?, 2 No autopsy death? 1 Yes 2 No 25. Was case referred to medical Certificate: To Be 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 No Inpatient ER/Outpatient 3 DOA 27. Manne of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 Natural 5 Pending 1 Yes 2 No Investigation 6 Could not be Accident 3 Suicide 4 Homicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined To the Hospital within 24 hours a To the Funeral E Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier 2 Medical Examine
3 Certifying Narse on the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated actioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certifie 29c. License number

State Registrar 31. Date filed (Month, Day, Year)
DEC 2 9 2009

MI

who completed cause of death (Item 23a) (Type, Print)

1328 Southe

MD

D0055120

m avenue SE Surte 310 Washington

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death

		-	For State Registrar	State of Ma	iryiand / D	epariment of F Ce <i>rtificate of L</i>	Death	rentai riye	Reg. No. 2009	42968			
	Physicia	n/	1. Decedent's Name (First, Middle, La Yvette N.	Martin				2. Date of Dea		3. Time of Death 10:45 A м			
	Medic → Examin	_	4a. Facility Name (if not institution, give				Location of Death		4c. County of Dea	th			
12	<u> </u>		5517 Belva Place		d I+ L:-+L-	Lanhar		8. Date of Birth	Prince C	thplace (State or Foreign			
	Funeral Director		5. Social Security Number 6. S 573-58-8817 Usual Residence of Decedent	OX3	(In yrs. last birtho	Months Days	Hours Min.	(Month, Day FeD • 1) 1941 Cal	inplace (State of Foreign			
	yland f show ed at	tor											
	e Mar	Direc	Maryland Prince	Georges	Lanham	10f. Zip Code			10g. Citizen of What Co	Yes 2 No			
	with th	Funeral Director	5517 Belva Place			20706			U.S.A.	Junity :			
920	1 and 2 should be filed within 72 hours after death with the Maryland f Health and Mental Hygiene. item 27 is marked other than "natural", or items 23a or 28a-f show item 27 is marked other than "natural", or items 25a or 28a-f show other traumatic event, the Medical Examiner must be notified at	ed by Fun	11. Marital Status 1 ☐ Never Married 2 ☐ Married 3 ☑ Widowed 4 ☐ Divorced	12. Was Decedent Exammed Forces? 1 Yes 24 If Yes, Give Year or Dates.		13. Was Decedent of H If Yes, specify Cuba 1 Yes 2 No		ecify Yes or No- Rican, etc.)	14. Race - Ame Black, Whit Specify: Whi	e, etc.			
21215-0036	hin 72 hou ne. than "natu e Medical	Completed by	15. Decedent's (Specify only highest g Elementary/Seconday (0-12)		+) (Give kind of work done of ife. DO NOT use retired)			16b. Kind of Business Self Emplo	·			
2	led within Hygiene. other thai	Be C	17. Father's Name (First, Middle, Last)		Co	aregiver	18. Mother's Nam	e (First, Middle, I	Maiden Surname)	Jy Cu			
/lan	d be file Aental arked c	입	Wilbur McCory				Pauline						
, Maryland	and 2 should Health and M tem 27 is mai		19a. Informant's Name/Relationship (Jack Rumble (part		19b.	Mailing Address (Street a 5517 Belva 1	and Number or Run Place Lan	ham, MD	; City or Town, State, Zi 20706	ip Code)			
Baltimore,			20a. Method of Disposition 1 Burial 2 Cremation 3 4 Donation 5 Other (Spec		cemetery	Disposition (Name of crematory or other place cake Crema	ce)	Date 29/09	20c. Location - City of Beltsville				
Balt	permit. Page Department of Important: If any injury or		21. Signature of Funeral Service Licer	Laterno	نف		polis Rd.	Lanham	le Funeral , MD 20706	Hame			
-	Physician/		23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition										
-	Medical Examiner		resulting in death)	Due to (or as a	consequence of):							
	ed sit	miner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury	b. Due to (or as a consequence of):									
_	ath certificate be executed attending physician and for use as the burial-transit	ledical Examiner	that initiated events resulting in death) Last	C. Due to (or as a	consequence of):			· · · · · · · · · · · · · · · · · · ·				
3760	ficate I g phys	/edi		- a	-								
Box 68	To the Hospital or Attending Physician: The law requires that the death certification within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending completed filled in by the funeral director, page 2 should be detached for use a	Physician/N	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☑ No 9 ☐ Unknown	23c. If yes, outcome of 1 Live Birth 4 Pregnant at 9 Unknown	2 Fetal death	3 ☐ Ectopic pregnand 5 ☐ Other (specify) _	ру		23d. Date of de Month	blivery Day Year			
s, P.O.	ires that the des signed by the s d be detached	þ	Part II. Other significant conditions				ven in Part I.		obacco use contribute t	o the cause of death? Probably 4 Unknown			
cord	law require has been si e 2 should b	Completed						24a. Was autop		utopsy findings available completion of cause of			
I Re	sician: The law is certificate has the lirector, page 2 s		25. Was case referred to medical			26. P	lace of Death (Chec	1 🗆 Yes	2-1 No 1 76	es 2 No			
Vita	ysicia is cert direct	To Be	examiner? 1 Yes 2 No	Hospital: 1 Inpatie	ent 2 ER/Out	patient 3 DOA Oth	er: 4 Nursing H	ome 5 Resid	lence 6 Other (Spe	cify)			
Division of Vital Records,	nding Ph ath. r: After th	Certificate:	27. Manner of Death 1 Natural 5 Pending 2 Accident Investigati		y Year) 28b. Ti	jury work		28d. Describe h	28d. Describe how injury occurred				
Division	al or Atte s after de l Directo		3 Suicide 6 Could not 4 Homicide determine			m, street, factory, office		28f. Location (S City or Tow	Street and Number or Ri vn, State)	ural Route Number,			
_	To the Hospital or Attending Physician: The k within 24 hours after death. To the Funeral Director: After this certificate h completed filled in by the funeral director, page	Medical	(Check 2 Medical Example (Check 2 Medical Example)	niner: On the basis of ex	camination and/or	leath occured at the time investigation, in my opini- edge, death occurred at the	on, death occurred a	it the time, date a	nd place, and due to the	cause(s) and manner stated.			
ø	Voithi Com		29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day Sept.) 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Stuart J. Turklwitz, M.D. 7500 Greenway Cfr. Dr. Greenb										
R	3		30. Name and address of person who	completed cause of de		ype, Print) - 7506 (-	reenila	y Ctr. c.	Dr. Green	bost Md			
	Sta Registr		31. Date filed (Month, Day, Year) UEC 2 9 2009	32. Registr	's Signature	1		/					

DHMH 17 Rev 7/2009

09-09886 Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. 2009 42969 State of Maryland / Department of Health and Mental Hygiene Hellen W Merkel 1. For State Certificate of Death Reg. No. Registrar 1. Decedent's Name (First, Middle,Last) 2. Date of Death Physician/ Helen Merkel December 20, 2009 0820 hrs al Examiner 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death c. County of Death 5245 Knights Bridge Court Saint Leonard Calvert 5. Social Security Number 8. Date of Birth(MM/DD/YYYY 9. Birthplace (State or 6 Sex If Under 1 Year If Under 24Hrs **Funeral** 7. Age (In vrs. last birthday) May 30 1920 167-16-3838 89 Months Days Hours Pennsylvania Director 1 M 2 F Yrs Usual Residence of Deceden 10d. Inside City Limits 10a. State 10b. County 10c. City, Town or Location 1 Yes 2 X No Calvert St. Leonard Maryland Pages I and 2 should be filed within 72 hours after death with the Maryland neart of Health and Mental Hygiene.
ant: If item 27 is marked other than "natural", or items 23a or 28a-f she or other traumatic event, the Medical Examiner must be notified at once. Director 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 20685 United States 5245 Knights Bridge Court Funeral 12. Was Decedent Ever in U.S 13. Was Decedent of Hispanic Origin? (Specify Yes or No-14. Race - American Indian, Black, Armed Forces? If Yes, specify Cuban, Mexican, Puerto Rican, etc.) White etc. 1 Never Married 2 Married Yes white Yes 2 No specify: 3 X Widowed Yes, Give Yee Specify Divorced ₫ 16a. Decedent's Usual Dccupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Completed Elementary/Secondary (0-12) College (1-4 or 5+) timore, MD 21215-0036 seamstress clothing 17. Father's Name (First, Middle, Last) 18.Mother's Name (First, Middle, Maiden Surname) Be William Monack Mary Kresak 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Gary J. Merkel - son 5245 Knights Bridge Ct. St. Leonard, MD 20685 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery Date 20c. Location - City or Town, State crematory or other place) 1 Burial 2 Cremation 3 Removal from State Lawnview Cemetery Dec 28 2009 FoxChase PA Donation 5 Other Specify. 5 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Rausch Funeral Home, PA 23a Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. 20676 Approximate Interval hysician Between Onset and Medical Death a. Atherosclerotic Cardiovascular Disease Immediate Cause (Final disease ≟xaminer or condition resulting in death) Due to (or as a consequence of): Sequentially list conditions, Due to (or as a consequence of): Examiner if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated Due to (or as a consequence of): events resulting in death) Last Physician/Medical UNPENDED AMENDED signed by the attending physician be detached for use as the burial Division of Vital Records, P.O. Box 68760, IE EEMALE 23d. Date of delivery 23c. If yes, outcome of pregnancy 23b. Was decedent pregnant in the Live birth 3 Ectopic pregnancy Month Year Fetal death Day 2 past 12 months? Pregnant at time of death 5 Other (Specify) 1 Yes 2 V No 9 Unknown Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I 23e. Did tobacco use contribute to the cause of death? <u>≨</u> 1 Yes 2 No 3 Probably 4 Unknown Completed 24a. Was an 24b. Were autopsy findings available autopsy prior to completion of cause of performed? death? Yes 2 V No 1 Yes 2 No 25. Was case referred to medical 26.Place of Death (Check only one) Be examiner? ER/Outpatient 3 DOA Inpatient 2 Nursing Home 5 Residence 6 🗸 Other: Scene this 1 🗸 Yes After 28a. Date of Injury (Month, Day, Year) 27. Manner of Death 28b. Time of Injury 28c. Injury at Work? 28d. Describe how injury occurred 1 🗸 Natural Pending Yes 2 No 2 Accident Investigation 28e. Place of Injury - At home, farm, street, factory, office building, etc 28f. Location (Street and Number or Rural Route Number, City 3 ___ Could not be Suicide determined 4 Homicide 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Sal 2 Wedical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 29b. Signature and title of certifie 29c. License number 29d. Date signed (Month, Day, Year) O.C.M.E. December 22, 2009

31. Date filed (Month, Day, Year State Registra

Assistant Medical Examiner 32. Registrar's Signature

30. Name and address of person who completed cause of death (Item 23a)

DEC 23 2009

Patricia Aronica-Pollak MD.

111 Penn Street, Baltimore, MD 21201

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death December 21, 2009 7:18 AM Wolf Mirocznik Hersz 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Washington Adventist Hospital Takoma Park Montgomery 5. Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign 1 ★ M 2 □ F Months Days Hours (Month, Day, Year) 579-13-7583 Poland ctober Usual Residence of Decedent 10b. County 10c. City. Town or Location 10d. Inside City Limits Montgomery Silver Spring 1 XYes 2 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 3520 Pear Tree Court Apt 24 20906 U.S.A 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-14 Race - American Indian Armed Forces?
1 ☐ Yes 2 ☑ No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Black, White, etc. 1 Never Married 2 Married If Yes, Give 1 ☐ Yes 2 No Specify: Specify: White 3 ₩ Widowed 4 Divorced Year or Dates 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) Travel Agent Travel 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname)

or 28a-f show notified at 72 hours after death with the Maryland d Mental Hygiene. marked other than "natural", or items 23a or matic event, the Medical Examiner must be r Baltimore, Maryland 21215-0036 permit. Page 1 and 2 should be filed within 72 Department of Health and Mental Hygiene. Important: If item 27 is marked other than "rany injury or other traumatic event, the Mad once.

Physician/

Medical

10a. State

MD

Director

Funeral

þ

Completed

Be

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Examiner

Funeral

Director

Physician/ Medical Examiner

Hospital or Attending Physician: The law requires that the death certificate be executed burial-transi and attending physician use as the for signed by the a cate has been sig ; page 2 should b certificate funeral director,

Division of Vital Records, P.O. Box 68760

Examiner Physician/Medical Completed by Be မှ

25. Was case referred to medical examiner? 1 Yes 2 HO 27. Manner of Death Medical Certificate: 1 Natural

21. Signature of meral Service Licensee Edward M00910 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line Immediate Cause (Final resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury that initiated events resulting in death) Last IF FEMALE: 23b. Was decedent pregnant in the past 12 months?

1 Yes 2 No 1 ☐ Yes 2 ☐ Unknown

Accident
Suicide

4 Homicide

Berl Mirocznik

20a. Method of Disposition

19a. Informant's Name/Relationship (Type, Print)

1 Burial 2 Cremation 3 E Removal from State

Jorge Mirocznik/Son

4 Donation 5 Other (Specify)

Due to (or as a consequence of) RENA 4 ☐ Pregnant a 9 ☐ Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

CARCINOMA Due to (or as a consequence of): 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death Ectopic pregnancy Pregnant at time of death 5 Other (specify)

1 Departient 2 ER/Outpatient 3 DOA

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28b. Time of

injury

SEPTIC

20b. Place of Disposition (Name of

Chesed Shel Emes

SHOCK

24a. Was an autopsy performed?

City or Town, State)

Hinde Rappaport

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 108 Watkins Mill Road #E Gaithersburg, MD 20879

Date

12/24/2009

22. Name and Address of Fac**Danzansky-Goldberg Memorial** 1170 Rockville Pike, Rockville, MD 20852

> 23e. Did tobacco use contribute to the cause of death? 1 Yes 2 ANO 3 Probably 4 Unknown

Day

Year

Approximate Interval Between Onset and Death

24b. Were autopsy findings available prior to completion of cause of death? 1 Yes 2 No 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 28d. Describe how injury occurred

23d. Date of delivery

Month

20c. Location - City or Town, State

Washington DC

		/			
29a. Certifier	1 Certifying Physicia	an: To the best of my knowledge, death occur-	ed at the time, date and place, ar	nd due to the c	cause(s) and manner as stated.
(Check	2 Medical Examiner:	: On the basis of examination and/or investigation	on, in my opinion, death occurred a	t the time, date	and place, and due to the cause(s) and manner stated
only one)	→ 3 ☐ Certifying Nurse P	ractioner: To the best of my knowledge, death	occurred at the time, date and place	ce, and due to t	the cause(s) and manner as stated.
Oh Signatura	and title of certifier	-	20a License sumber		00 D

24Amin, MD

2009

24

5 Pending

Investigation 6 Could not be

determined

28c. Injury at work? 1 ☐ Yes 2 ☐ No

29d. Date signed (Month, Day, Year 12/21/2009

28f. Location (Street and Number or Rural Route Number.

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)
SHAHLOD SHAMIM, ND, WASHIMTON ADVENTUT HOSPITAL, TAKOMA PAKEN, HD-20912

Hospital:

28a. Date of injury (Month, Day, Year)

31. Date filed (Month, Day, Year) **State** Registrar

Registrar's Signat

24 hours after death. Funeral Director: A

within 2 To the F

completed filled in by

State of Maryland / Department of Health and Mental Hygiene State
Registrar AMEND#20bperFH, 12/14/09, BWW, MbCo Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician Month December 23, Year 2009 Lorraine Nromie McQuitty 7:45 a M aka Lorraine Naomi McQuitty /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** 4c. County of Death Prince George's Renaissance Gardens at Riderwood Village Silver Spring 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Ye Jan. 31, 9. Birthplace (State or Foreign **Funeral** Year) Months Days Hours Min. 1 □ M 💯 □ F 433-20-2323 85 Director 1924 Louisiana Usual Residence of Decedent death with the Maryland 10a. State 10b. County 10c. City, Town or Location r than "natural", or items 23a or 28a-f show the Medical Examiner must be notified at 10d. Inside City Limits Directo 1 ☐ Yes 2 🐴 No Maryland P.G. Silver Spring 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 3160 Gracefield Road, #3319 20904 USA Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☑ No 11. Marital Status Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. Pages 1 and 2 should be filed within 72 hours after nent of Health and Mental Hygiene. ☐Yes 2 Yes, Give 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 TNo <u>۾</u> Specify: Specify: White 3 ₩ Widowed 4 Divorced Year or Dates Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) 12 Homemaker Own Home 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be permit. Pages 1 and 2 should be Department of Health and Menta Important: If item 27 is marked any injury or other traumatic ev Ernest J. Lotz Eugenie A. Francinques ٩ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Robert John McQuitty/Son 4933 Brampton Pkwy., Ellicott City, MD 21043 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State tx☐ Burial 2 ☐ Cremation 3 ☐ Removal from State Dec. 29, 2009 Gate of Heaven Cemetery 4 ☐ Donation 5 ☐ Other (Specify) Silver Spring, Maryland 2. Name and Address of Facility
Francis J. Collins Funeral Home Inc.

Silver Spring, MD 20901 21. Signature of Funeral Service Licensee 500 University Blvd. W., 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** Pneumonia 2 weeks disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Usease or impury that initiated events resulting in death) Last Examine Due to (or as a consequence of) requires that the death certificate be executed and burial-tra Due to (or as a consequence of): Box 68760. attending physician Physician/Medical as the IF FEMALE: nse yes, outcome of pregnancy
Live birth 2 D Fetal death
D Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy Por in the past 12 months? Month Year Day signed by the a 5 Other (specify) 1 □Yes 2 🗷 No P.O. 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Records, Congestive Heart Failure 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown page 2 should Completed been 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed' Division of Vital 1 □ Yes 2 🔣 No 2 🗆 No Physician: 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No ၉ 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 28a. Date of Injury (Month, Day, Year) funeral ne Hospital or Attending P n 24 hours after death. ne Funeral Director: After t Certification: 27. Manner of Death 28b. Time of After 28c. Injury at Work? 28d. Describe how injury occurred 1 V Natura 5 Pending Injury 2 Accident investigation 1 ☐ Yes 2 ☐ No completely filled in by the 3 Suicide 6 Could not be determined 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical 29a. Certifier (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. To the within 2 29b. Signature and titl 29c. License number 29d. Date signed (Month, Day, Year) D24093 Dec. 23, 2009 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 3110 Gracefield Road, Silver Spring, MD 20904 Mark Parkhurst, MD 31. Date filed (Month, Day, Year) 32. Registrar's Signature State garle Registrar

		1 - State Registrar	e of Maryland	l / Depa Cen	artment of H	lealth and I Death		giene 2 (009	42972
Physicia	ın/	Decedent's Name (First, Middle, Last)	Deeds McD				2. Date of De Month Decemb	ath	2 00 0 9	3. Time of Death 4:42 M
Medic Examin		4a. Facility Name (if not institution, give street and Joseph Home		onaca	-	Location of Death	1	4c. Count	ty of Death Montg	
Funeral Director		5. Social Security Number 320-22-6686 Usual Residence of Decedent	7. Age (In yrs. las	t birthday) Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Bir		9. Birthp Count Wash	place (State or Foreign try) Lington, DC
Maryland 28a-f show otified at	irector	10a. State 10b. County Maryland Prince Georg	,	Town or Loc		Laurel				0d. Inside City Limits 1 ☐ Yes 2 🛣 No
h with the ns 23a or must be n	Funeral Director	10e. Street and Number 7305 Brooklyn Brid			10f. Zip Code	20707		10g. Citizen of	u.s	.A.
permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If tiem 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.	by	Armed	Decedent Ever in U.S. If Forces? If Some Some Some Some Some Some Some Some	If	Vas Decedent of His Yes, specify Cubar ☐ Yes 2 뀞 No	n, Mexican, Puerto	ecify Yes or No- o Rican, etc.)		ace - America ack, White, e fy:	
ithin 72 hou ene. r than "natu the Medical	Completed	15. Decedent's Education (Specify only highest grade completed in the comp	eted) e (1-4 or 5+)	(Give k	ent's Usual Occupa ind of work done d NOT use retired) I NS LU	uring most of work	king	16b. Kind of E		_{dustry} Lephone
d be filed w Mental Hygi arked other atic event, 1	To Be	17. Father's Name (First, Middle, Last) John Francis Deed	\$		170570 0	18. Mother's Nam	ne (First, Middle, Nyra Agn	Maiden Surnan	ne)	ceonone
and 2 shoul fealth and P em 27 is me her traums		19a. Informant's Name/Relationship (Type, Print) Maryann McDonald - Dau		7305	g Address (Street a Brooklyn		Road, La	urel, M	laryla	nd 20707
iit. Page 1 and ment of hartment of hortant: If ite injury or ot		20a. Method of Disposition 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal of a Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee	rom State Gate	metery, crem 2. 0 { H	sition (Name of patory or other place Cer	n. 12/2			r Spri	
Depart Impo any any		23a. Hart 1. Enter the disease, or complications to		11	800 New t	lampshire	e Ave.,	Silver		g, MD 20904 Approximate
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ath certific attending p for use as	Physician/Me	in the past 12 months?	outcome of pregnand live Birth 2 Fetal Pregnant at time of de Jnknown	death 3 🗌	Ectopic pregnanc Other (specify)	у			ate of delive	ery Day Year
requires that the de been signed by the should be detached		Part II. Other significant conditions contributing	to death but not resul	ting in the u	nderlying cause giv	en in Part I.				ne cause of death?
sician: The law rec s certificate has bee lirector, page 2 sho	Completed by						24a. Was auto perfo 1 \(\supers		. Were autop prior to cor death? 1 ☐ Yes	osy findings available mpletion of cause of 2 No
ysician: is certific director,	To Be	25. Was case referred to medical examiner? 1 Yes 2 No Hospital:	☐ Inpatient 2☐ E	B/Outpatien	_ Othe	er:		donos 6 📝 Ott	hor (Specify	Group Home
ending Phy eath. or: After thi he funeral o	Certificate: 7	27. Manner of Death 1 Natural 5 □ Pending 2 □ Accident Investigation		8b. Time of injury	28c. Injury work	at	ı	now injury occur		o code frome
To the Hospital or Attending I within 24 hours after death. To the Funeral Director: After completed filled in by the funer		4 ☐ Homicide determined b	lace of Injury - At hom uilding, etc. (Specify)				City or Tov			
the Hos nin 24 ho the Fune	Medical	29a. Certifier 1 X Certifying Physician: To to (Check 2 Medical Examiner: On the only one) 3 Certifying Nurse Praction	basis of examination a	and/or investi	igation, in my opinio	n, death occurred a	at the time, date a	and place, and di	ue to the cau	use(s) and manner stated.
3		29b. Signature and title of pertifier	ley.		29c. License	D42578		29d. Date signe Decembe		
		30. Name and address of person who completed Gul Chablani, MD, PC,	11119 Rock	rville		401, Rock	rville,	Marylar	ıd 208	52
Stat Registra		31. Date filed (Month, Day, Year) IFC 2.4 2009	2. Registrar's Signatu	re bar	Med.					

Baltimore, Maryland 21215-0036

Division of Vital Records, P.O. Box 68760

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Month Day Year anning comb 00 Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town or Location of Death 4c. County of Deat izabeth 150 arsing tim 8. Date of Birth (Month, Day, Y March 6, If Under 1 Year If Under 24 Hrs. 9. Birthplace (State or Foreign **Funeral** (In vrs. last birthday Year) 19<u>27</u> 1 □ M 2 □ F Days Hours Min. Months 024-20-3664 82 Yrs. Massachusetts Director Usual Residence of Decedent shov 10a, State 10b. County notified at 10c. City, Town or Location 10d. Inside City Limits Director 28a-f Maryland Howard Highland 1 Yes 2 No ō 10e Street and Number 10f. Zip Code 10g, Citizen of What Country? rral", or items 23a or Examiner must be Funeral 13550 Clarksville Pike 20777 USA 11. Marital Status 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Armed Forces? Black, White, etc. þ 1 X Never Married 2 Married hours after Baltimore, Maryland 21215-0036 White 1 ☐ Yes 2 🗵 No Specify: If Yes, Give Year or Dates "natural", Specify. Completed 3 Widowed 4 Divorced the Medical 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) 72 and Mental Hygiene. Department of Elementary/Seconday (0-12) College (1-4 or 5+) Justice Administrative Assistant injury or other traumatic event, Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ည James Edward Manning Helen Frances Schofield permit. Page 1 and 2 should be Department of Health and Ment Important: If item 27 is marke any injury or other traumatic o 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Sarah M. O'Leary/Sister 13550 Clarksville Pike, Highland, MD 20777 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State cemetery, crematory or other place)
St. Michael's Cemetery 1 ₺ Burial 2 ☐ Cremation 3 ₺ Removal from State Dec 2009 4 ☐ Donation 5 ☐ Other (Specify) Hudson, MA 22. Name and Address of Eacility
Francis J. Collins Funeeral Home Inc.
100 University Blvd. W., Silver Spring, 21. Signatur of Funeral Service Licensee 500 University Blvd. MD 20901 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate nterval Between Onset and Death Immediate Cause (Final Physician/ disease or condition resulting in death) Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or linjury that initiated events resulting in death) Last Due to (or as a consequence of): Examir and-tran Due to (or as a consequence of): attending physician for use as the buria Physician/Medical or Attending Physician: The law requires that the death certificate be Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?

1 Yes 2 No Month Year Day 5 Other (specify) Pregnant at time of death the Unknown Unknow P.O. þ Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. signed I 23e. Did tobacco use contribute to the cause of death? by nemi Records, Completed 1 Yes 2 No 3 Probably 4 Unknown peen 24b. Were autopsy findings available prior to completion of cause of 24a. Was an has page 2 autopsy performe death? certificate 2 🗆 No Yes Division of Vital 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Other: 1 🗌 Yes မ 1 Inpatient 2 ER/Outpatient 3 DOA 4X Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) this funeral n 24 hours after death.

The Funeral Director: After the pleted filled in by the funeral 27. Manner of Death 28a. Date of injury (Month, Day, Year) Certificate: 28c. Injury at 28b. Time of 28d. Describe how injury occurred Natural work?
1 Yes 5 Pending 2 🗌 No Accident Investigation Suicide Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Hospital Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. To the I within 2 To the I complet 3 🗆 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29b. Signature and title of certifier 29c. License number ans 200 22

Registrar

DHMH 17 Rev 7/2009

State

enson

Registrar's Signatur

2122

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

3320

(Month, Day, Year)

Date filed

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene.

		,	1- For State of Maryland / Department of Health and Per dr., 8899,01/12/10dhb Certificate of Death	d Mental Hy	ygien Reg. No	^e 200	9	42974
	Physici		1. Decedent's Name (First, Middle, Last) SANDRA JEAN MARTEN	2. Date of D Month DEC . 1	eath 7 - 21	n n	ar	3. Time of Death
1	/Medio Examin		4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of De		40	. County of D	eath	• 1 3/1 •
-0"	Funeral	-	GENESIS LA PLATA CENTER 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 H	rs. 8. Date of B		HARLES		e (State or Foreign
	Director		389-46-9569 1□ M 2 F 57 Yrs. Months Days Hours M	rs. 8. Date of B (Month, D 7 – 24	– 19 !	52 WI	LS.	
	iryland show	_	10a. State 10b. County 10c. City, Town or Location					Inside City Limits
	the Ma	Director	MD • CHARLES WHITE PLAINS 10e. Street and Number 10f. Zip Code		10a C	itizen of What		1 ☐ Yes 2 ☐ No
	th with		4224 JAMBEAU PLACE 20695			S.A.	Country	
036	be flied within 72 hours after death with the Maryland Hygiene. d other than "natural", or items 23a or 28a-f show event, it e Madical Expridirer must be rediffed at	by Funeral	11. Marital Status 12. Was Decedent Ever in U.S. Armed Forces? 1 □ Never Married 1 □ Never Married 1 □ Never Married 1 □ Never Married 1 □ Yes 2 □ No If Yes, Give Year or Dates: 1 □ Yes 2 □ No Specify:	(Specify Yes or N erto Rican, etc.)	0-	14. Race - Al Black, WI Specify:WH	hite, etc.	·
2-0	"natur	leted	15. Decedent's Education (Specify only highest grade completed) [Give kind of work done during most of work done during	orking		Kind of Busine		
21215-0036	d within giene. er than	Completed by	Elementary/Secondary (0-12) 12 College (1-4or 5+) WAREHOUSE MANAGER			RECTI AMERI		CORP.
and	eve d	Be	17. Father's Name (First, Middle, Last) 18. Mother's N	ame (First, Middle				
ar y	12 should th and Mer 7 is marke traumatic	ဥ	19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or	SE KOCI: Rural Route Numi			e, Zip Coi	ide)
Š o	s 1 and 2 if Health a item 27 is other tra		JOHN P.BOLLMAN-SON 4224 JAMBEAU PLACE	E WHITE	PLA	AINS,M	ID.2	0695
Baltimore, Maryland	e = 12 de		20a. Method of Disposition 1 □ Burial 2X Cremation 3 □ Removal from State 4 □ Donation 5 □ Other (Specify) 20b. Place of Disposition (Name of cemetery, crematory or other place) METROPOLITAN CREMATORY 12	Date 2 _ 1 8 _ 0 9		ocation - City		State
Balti	permit. Pag Departmen Important: any Injury once.		21. Signature of Funeral Service Licensee MO0479 22. Name and Address of Facility RAYMOND FUNERAL	SERVI	CE.E			
	Physician /Medical Examiner		23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as card shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) a. Due to (or as a consequence of):	iac or respiratory	arrest,		V On	pproximate perval Between aset and Death WCS.
	xecute and I-transit	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last b. Due to (or as a consequence of): c. Due to (or as a consequence of): Due to (or as a consequence of):				FL	JKS.
09/89	nificate be executed by physician and as the burial-transit	ledical E	Co. Stypertusm				K	moulte
Š .	e attendir d for use	Physician/M	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 4 ☐ Pregnant at time of death 5 ☐ Other (specify)			23d. Date of o	delivery Day	y Year
ords, P	requires that the seen signed by the hould be detache	þ	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.		tobacco Yes 2		to the ca	ause of death?
Hec	in: The law rificate has bor, page 2 sh	e Completed	25. Was case referred to medical	1 ☐ Yes	psy ormed? 2 2 No	prior t death	to comple	findings available etion of cause of
OT V	r this certific ral director,	To B	examiner?	eath <i>(Check only</i> Home 5 ☐ Res		6 □Other (S	pecify)	
_ 1	After t funera	tion:	27. Manner of Death 1 ☑ Natural 5 ☐ Pending 28a. Date of Injury 28b. Time of Injury 28c. Injury at Work?	28d. Describe				
DIVISION	volunion 24 hours after death. To the Funeral Director: After this certificate he completely filled in by the funeral director, page	Certification:	2 ☐ Accident investigation 3 ☐ Suicide 4 ☐ Homicide 6 ☐ Could not be determined 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)	28f. Location (City or To	Street ar wn, State	nd Number or e)	Rural Ro	oute Number,
	nospinospinospinospinospinospinospinospi	edical	29a. Certifier (Check only one) Certifying Physician: To the best of my knowledge, death occurred at the time, date and plate	ice, and due to the curred at the time	e cause(s , date an	s) and manner d place, and d	as stated	d. cause(s)
F	Northi Com	Ž	29b. Signature and title of certifier 29c. License number	0624		ite signed (Mo		
		-	30. Name and address of person who completed cause of death (Item 23a) (Type, Print)	m 1/1.	Dec	ember 1	.0,	200 9
	(/) Stat	e_	31. Date filed (Month, Pay, Year) 32. Jegistrar's Signature	コヘカル	U II	1 A A CO	1	0607
	Registra	ır	31. Date filed (Month, Day, Year) JAN 12 2010 32. Jegistrar's Signature A. January J.					

DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State RegistrarAmended item#8, WCHD, 41.5.10, Certificate of Death SLU 1. Decedent's Name (First, Middle, Last) Physician/ 2. Date of Death William Orville Mason Medical **Examiner** Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death . ENINSULA REGIONAL 34/156414 Vicomico Social Security Number Funeral 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign Country) Maryland 212-18-6939 1 X M 2 D F **Director** Hours (Month, Day, Year 4/23/192 86 Yrs Usual Residence of Decedent ural", or items 23a or 28a-f show Examiner must be notified at within 72 hours after death with the Maryland 10a. State 10c. City, Town or Location 10d. Inside City Limits Direct Maryland Wicomico Bivalve 1 Yes 2 X No 10e. Street and Number 10f. Zip Code Funeral 10g. Citizen of What Country? 21223 Nanticoke Road 21814 USA 11. Marital Status 12. Was Decedent Ever in U.S. Armed Forces?

1 | | X| Yes 2 | | No | No | No | No | No | No | Year or Dates. | No | I Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. 'natural", or ģ 1 Never Married 2 X Married Baltimore, Maryland 21215-0036 Completed 3 Widowed 4 Divorced 1 Yes 2 No Specify: Specify. white the Medical 15. Decedent's Education 16a. Decedent's Usual Occupation (Specify only highest grade completed) 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) permit. Page 1 and 2 should be filled with Department of Health and Mental Hygier Important: If item 27 is marked other t. any injury or other traumatic event, the Once. heavy equipment operator city government Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ည George William Mason Hilda Fluheart 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 21223 Nanticoke Rd., Bivalve, MD 21814 Frieda Mason/spouse 20a. Method of Disposition 20b. Place of Disposition (Name of Date Burial 2 Cremation 3 Removal from State 20c. Location - City or Town, State springhill Memory 5 Other (Specify) Depation 12/28/09 Hebron, MD nature of Funera Service 22 Name and Address of Facility
HOLLOWAY Funeral Home Professional tol Association 501 Snow Hill Rd., Salisbury, MD 21804 art 1. Enter the disease, or complications that caused the shock, or heart failure. List only one cause on each line. death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ disease or condition resulting in death) Congestive Medical Due to (or as a consequence of): Examiner Corenany Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Examiner Due to (or as a consequence of) signed by the attending physician and d be detached for use as the burial-transit Due to (or as a consequence of): that initiated events resulting in death) Last Physician/Medical death certificate be Division of Vital Records, P.O. Box 68760 IF FEMALE 23b. Was decedent pregnant 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death
4 Pregnant at time of death in the past 12 months? 23d. Date of delivery 3 Ectopic pregnancy Pregnant at time of death 5 Other (specify) Month 9 Unknown Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. δ 23e. Did tobacco use contribute to the cause of death? Completed peen 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Hospital or Attending Physician: The law has 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? Yes 2 No this certificate 2 🗌 No 25. Was case referred to medical 1 Tyes Be 1 Yes 26. Place of Death (Check only one) 2 No ഉ Other: 1 Inpatient 2 ER/Outpatient 3 IDOA 4 Nursing Home 5 Residence 6 Other (Specify) 27. Manner of Death 28a. Date of injury (Month, Day, Year) Certificate: After 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 Natural 5 Pending n 24 hours after death, le Funeral Director: A pleted filled in by the fu work? Accident Investigation 2 No Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide determined 28f. Location (Street and Number or Rural Route Number, City or Town, State Medical Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier within 24 ho
To the Fune
completed fi (Check Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certifier 29c. License number D68222 TINT

1VA State

Registrar

gistrar's Signature

SAlisbury md 2180

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

		For State	State of I	Marylar		artment of I		d Me	ntal Hy	giene	2009	42976
	_	Registrar 1. Decedent's Name (First, Middle	(a l ast)		Cer	tificate of L	Death			Reg. No.	2003	
Physici		Lorraine Rede							Date of Dea Month ec 25,		Year	3. Time of Death
Med Exami		4a. Facility Name (if not institution				4b. City, Town, o	r Location of De		ec 25,		County of Dea	0.00 A
2		Collington Ep	iscopal Lif	e Car	e	Mito	chellvil	11e			,	George's
Funera Directo		5. Social Security Number 308–18–4822	6. Sex 1 □ M 2 🖾 F	Age (In yrs. i	ast birthday) Yrs.	If Under 1 Year Months Days	If Under 24 H Hours M	Hrs. 8. Iin. S€	Date of Birt (Month, Day ptember	h , Year) c 28, 1	9. Bi Co 1921 Los	rthplace (State or Foreign ountry) gansport, IN
nd how at	٦	Usual Residence of Decedent 10a. State 10b. County	,	10c. Cit	y, Town or Loc	ation						10d. Inside City Limits
faryla 8a-f s tified	Director	Maryland Princ	ce George's	Mit	chellv	ille						1 ⊠ Yes 2 □ No
the Na or 2	ä	10e. Street and Number				10f. Zip Code				10g. Citi	zen of What C	ountry?
h with ns 23; must I	Funeral	10450 Lottsfo				20	721				USA	
ire, Maryland 21215-0036 1 and 2 should be filed within 72 hours after death with the Maryland of Health and Mental Hygiene. Item 27 is marked other than "natural", or items 23a or 28a-f show other traumatic event, the Medical Examiner must be notified at	2	11. Marital Status 1 □ Never Married 2 □ Mar 3 ☒ Widowed 4 □ Divorced	If Yes, Give	s? XI No	lf	/as Decedent of H Yes, specify Cuba ☐ Yes 2 X No	n, Mexican, Pu	(Specify erto Rica	Yes or No- an, etc.)	ĺ	14. Race - Amo Black, Whit Specify: Wh	te, etc.
5-0C hours natura lical E	Completed	15. Decede	ent's Education			ent's Usual Occup					nd of Business	
215 lin 72 le. han "u	1 6	(Specify only higher Elementary/Seconday (0-12)	est grade completed) College (1-4 o	r 5+)	(Give k life. DC	ind of work done of NOT use retired)	during most of w	vorking]			madsby
d with ther that	BeC	12		<u>.</u>	Home	emaker					n Home	
Maryland 21215-0036 2 should be filed within 72 hours after th and Mental Hygiene. 27 is marked other than "natural", o traumatic event, the Medical Exam	P	17. Father's Name (First, Middle, I	Last)				18. Mother's N			Maiden S	Gurname)	
ary nould nd Me mark	П	19a. Informant's Name/Relations	hip (Type, Print)		19h Mailin	g Address (Street a			_	City or	Town State 7	in Cadal
d 2 shaalth ay		Stephanie Wol		r		ape Sain						•
		20a. Method of Disposition 1 X Burial 2 Cremation	2 Pamoual from Sta	20b. F	Place of Dispos	sition (Name of atory or other plac	- 1	Date	1		cation - City or	
Limor Bage 1 Iment of 1 tant: If it		4 Donation 5 Other (S		Mot	ınt Hop	e Cemete	ry 1/4	4/20	10	Loga	nsport	, Indiana
Baltimore, permit. Page 1 and Department of Hea Important: If item any injury or other once.		21. Signature of Funeral Service I	Licensee RAy Rogeas	•		Name and Addres	-	ome.	P.A.			imore Ave. le, MD 20781
		23a. Part 1. Enter the disease, or shock, or heart failure. List of	complications that caus	ed the deat	h. Do not ente	r the mode of dyin	g, such as cardi	iac or re	spiratory arm	est,	000111	Approximate Interval Between
Physician/ Medical		Immediate Cause (Final disease or condition resulting in death)	a. Uroseps		Ionco off:							Onset and Death 2 Weeks
Examiner			Failure									6 Months
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scuted and transi	xam	Cause (Disease or linjury that initiated events	C									
f 60 cate be executed physician and the burial-transit	<u>8</u>	resulting in death) Last	Due to (or a	s a consequ	ience ot):							
Certificate be executed certificate be executed inding physician and use as the burial-transi	ledical		d									
BOX death the atte	Physician/M	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☒ No 9 ☐ Unknown	23c. If yes, outcom 1 Live Birth 4 Pregnant 9 Unknowr	n 2 □ Feta :at time of d	ıldeath 3 🗌	Ectopic pregnand Other (specify)	у			2	3d. Date of de Month	elivery Day Year
that the ned by t	by Pr	Part II. Other significant condition	ns contributing to death	but not res	ulting in the ur	derlying cause giv	en in Part I.		23e. Did tol	bacco us	e contribute to	the cause of death?
uires t uires t n sign	ed b	Upper Gastroi	ntestinal B	leedi	ng				1 🗆 Y	es 2 🔀	No 3□P	robably 4 🗆 Unknown
VITAI KECOTGS, ysician: The law requires is certificate has been sig director, page 2 should b	Completed	Dementia							24a. Was a		24b. Were au	topsy findings available completion of cause of
The cate h		Coagulopathy							perfor 1 Yes	med?	death?	s 2 🗆 No
Ital sician certifi rector	Be	25. Was case referred to medical examiner? 1 Yes 2 No	Hospital:			Otho	ace of Death (Ch					
OT V ig Phys er this neral di	e: To	27. Manner of Death	28a. Date of in	jury	ER/Outpatient 28b. Time of	3 DOA 28c. Injury	4 LA Nursing		5 Reside		Other (Spec	sify)
ath.	icat	1 ☒ Natural 5 ☐ Pendin 2 ☐ Accident Investi		ay, Year)	injury	work	? Yes 2 □ No	200.	Describe no	w injury	occarred	
DIVISION lal or Attendir s after death. al Director: Af	l Certificate:	3 ☐ Suicide 6 ☐ Could 4 ☐ Homicide determ	inad 28e. Place of Ir	njury - At ho tc. <i>(Specify,</i>	me, farm, stree	et, factory, office		28f.	Location (St City or Town		Number or Ru	ral Route Number,
he Hospit iin 24 hour he Funera	Medical	l (Check 2 ⊔ Medical E	Physician: To the best of xaminer: On the basis of Nurse Practioner: To the	examination	and/or investig	ation, in my opinio	 death occurre 	d at the	time date an	d place a	and due to the	cause(s) and manner stated
To 1 To 1		29b. Signature and title of certifier				29c. License	number D47603		2		signed (Month	
R3		30. Name and address of person values 12158 Central					am DuBo	усе				
Sta Registr	te ar	31. Date filed (Month, Day, Year) DEC 2 9 2009		rar's-Signet	-	-						-

DHMH 17 Rev 7/2009

State of Maryland / Department of Health and Mental Hygiene 2 Certificate of Death Rea. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** Month Horst Albert Pohl /Medical 1820 December 25 2009 4a. Facility Name (If not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death 11801 Linbar Dr. Hagerstown Washington County 5. Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth (Month, Day, Year)

August 22,1922 Germany **Funeral** Birthplace (State or Foreign Country) 1X M 2□ F Months Days Hours Min 147-16-2926 Director 86 Usual Residence of Decedent permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examination and inferior or other traumatic event, the Medical Examination and inferior or other traumatic event, the Medical Examination and inferior once. 10c. City, Town or Location 10d. Inside City Limits Maryland|Washington County|Hagerstown Director 1 ☐ Yes 2 XNo 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 11801 Linbar Dr. 21742 U.S.A. by Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 XYes 2 ☐ No If Yes, Give Year or Dates: 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2X No Specify: 3 ☐ Widowed 4 ☐ Divorced Specify: White Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) 12 College (1-4or 5+) Tool & Cutter Grinder Truck Mfg. 17. Father's Name (First, Middle, Last) Be 18. Mother's Name (First, Middle, Maiden Surname) Albert Pohl Martha Ruskowski Pohl ပ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Norma Pohl-wife 11801 Linbar Dr. Hagerstown, MD 21742 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 N Burial 2 □ Cremation 3 □ Removal from State Cedar Lawn Mem Park 4 ☐ Donation 5 ☐ Other (Specify) 12-30-2009 |Hagerstown, Maryland 22. Name and Address of Facility Douglas A, Fiery Funeral Home 21. Signature of Funeral Service Licensee Eastern Blvd. North Hagerstown, MD 21742 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Onset and Death Physician Wrosepsis /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate the sequence of the Examiner Due to (or as a consequence of) burial-tra the death certificate be exect Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, ted by the attending physician detached for use as the buria Physician/Medical 23c. If yes, outcome of pregnancy 23b. Was decedent pregnant 23d. Date of delivery Live birth 2 Fetal death 3 Ectopic pregnancy in the past 12 months? Month l∐Yes 2 □No Day Year 5 ☐ Other (specify) 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ģ Parkinsons disease Completed 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 🕱 Unknown peen Chronic Kidney Disease 24b. Were autopsy findings available prior to completion of cause of death? has 24a, Was an certificate Diabetes Mellitus 2 🗆 No To the Hospital or Attending Physician: within 24 hours after death.

To the Funeral Director: After this certifica 1 ☐Yes 2 X No 1 🗆 Yes 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 1 Yes 2 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 28a. Date of Injury (Month, Day, Year) 27. Manner of Death Certification: 28b. Time of 28d. Describe how injury occurred 1 Natural 5 Pending investigation 2 Accident 1 ☐ Yes 2 ☐ No 3 Suicide 6 Could not be determined Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide Medical 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) D45563 12-29-2009 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) WH 9+1 324 East Antietom Street, Hagerstown, Maryland 21740 MD 31. Date filed (Month, Day, 32. Registrar's Signature State Year) **DEC 30** Registrar

DHMH 17 Rev 1/2001

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	pu		Usual Residence of Decedent				
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	h with	al D	17108 Thornton Date Ct. 20832		USA		
	r deal	Funeral	11. Marital Status 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispan If Yes, specify Cuban, M	anic Origin? (Specify Yes or Mexican, Puerto Rican, etc.)	No- 14.	Race - Ameri Black, White,	
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altimore,	Pages ment of ant: If its ury or o	Н	18 Burial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify) Arlington National Cen.	Feb. 17,2010	Arlin	gton, V	A
Rail	permit. Pages Department of Important: If i any injury or once.		21. Signature of Funeral Service Licensee 22. Name and Address of	Facility Greene	Funer	au Ho	me
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		10 B	23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, su shock, or heart failure. List only one cause on each line.	uch as cardiac or respiratory	arrest,		Approximate Interval Between Onset and Death
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5	ing Pl	ü	27. Manner of Death 1 ☑ Natural 5 ☐ Pending 28a. Date of Injury (Month, Day, Year) 28b. Time of Injury at Work?		e how injury oc		7
2	ttend death stor: / the f	cat	2 Accident investigation M 1 Yes 3 Suicide 6 Could not be 288 Place of Injury At home form about follows:				
2	after Direc	ertification:	4 Homicide determined determined 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)	281. Location City or T	(Street and Ni own, State)	umber or Rura	al Route Number,
	ospita hours uneral ly fille	<u>ဗ</u>	29a. Certifier (Check only (Check only 2 Medical Examiner: On the basis of examination and/or investigation in my opinion	fate and place, and due to the	ne cause(s) an	d manner as:	stated.
	To the Hospital or Attending Physician: The law requires that the death certific within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending completely filled in by the funeral director, page 2 should be detached for use as	Medical	one) and manner stated.		e, date and pla	ce, and due to	o the cause(s)
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ļ	5	-	30. Name and address of person who completed cause of death (Item 23a) (Type, Print)		1-124	1200	
2_			J Kouctchou, MD-6001 Muncaster Mill Rd R	ockuille, MDT	0855	,	
	Stat		31. Date filed (Month Day Year) / 32. Registrar's Signature				
	Registra	r	DEC 2 9 2009 Sener > B. Jak				

Physician
/Medical
Examiner

Funeral

Director f show event, the Medical Examiner must be notified at items 23a or 28a-f , o al Hygiene. other than "

Pages 1 and 2 should be filed within 72 hours after death with the Maryland 4537 DALLAS PLACE # 102 20748 Funeral Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 11. Marital Status 1 □Yes 2 □ No If Yes, Give Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☐ No Specify ð 3 Widowed 4 Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) 12TH HOUSEWIFE 17. Father's Name (First, Middle, Last) Be h and Mental h **EMERSON** BRIDIE PERCY ECHOLS 2 19a. Informant's Name/Relationship (Type. Print) Health 8 YVONNE RICHARDSON/DGT item 27 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20a. Method of Disposition Department of H Important: If ite any Injury or of once. Marial 2 ☐ Cremation 3 ☐ Removal from State HERITAGE CEMETERY 12/30/09 4 Donation 5 Dother (Specify) 22. Name and Address of Facility 21. Signature of Funeral Service Licensee Part 1. Enter the disease, * r complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. 23a. Part 1. Enter the disease Immediate Cause (Final **Physician** disease or condition resulting in death) CARDIAC ISCHEMIA /Medical Due to (or as a consequence of): Examiner HYPOTENSION Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examine DEMENTIA that the death certificate be executed Due to (or as a consequence of) Box 68760 attending physician for use as the buria Physician/Medical IF FEMALE 23c. If yes, outcome of pregnancy

1 Live birth 2 Fetal death
4 Pregnant at time of death 23b. Was decedent pregnant in the past 12 months? 3 Ectopic pregnancy 5 ☐ Other (specify) 1 □Yes 2 □No P.0. the 9 Unknown 9 Unknown δ Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Records, ğ Completed page 2 should 24a. Was an autopsy perform 1 ☐ Yes Division of Vital To the Hospital or Attending Physician: 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Be Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 1 Yes 2 No Certification: To 28a. Date of Injury (Month, Day, Year) 28b. Time of 27. Manner of Death 28c. Injury at Work? After 1X Natural 5 Pending within 24 hours after death.

To the Funeral Director: A completely filled in by the fil 1 Yes death. investigation 2 Accident 6 Could not be determined 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 29a. Certifier (Check only one) and manner stated. 29c. License number 29b. Signature and title of certifie md30509 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

32. Registra 's Signa ure

2. Date of Death 3. Time of Death Month Day Year 2009 DECEMBER 22 4:05 A LOIS RICHARDSON 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death CLINTON

Vaar | If Under 24 Hrs. FUTURECARE PINEVIEW NURSING HOME PRINCE GEORGE'S Birthplace (State or Foreign Country) 8. Date of Birth (Month, Day, Year) 5. Social Security Number Age (In yrs. last birthday) Hours Min Months Days 1 M 2 X F APRIL 18 1916 VIRGINIA 93 225-26-7619 Usual Residence of Decedent 10d. Inside City Limits 10a. State 10b. County 10c. City, Town or Location Yes 2 □ No Director PRINCE GEORGE'S TEMPLE HILLS 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code USA Race - American Indian. Black, White, etc. BLACK 16b. Kind of Business/Industry PRIVATE 18. Mother's Name (First, Middle, Maiden Surname) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 9120 TUMBLEWEED RUN UNIT K LAUREL, MARYLAND 20723 20c. Location - City or Town, State WALDORF, MARYLAND J. B. JENKINS FUNERAL HOME 7474_LANDOVER ROAD LANDOVER, MARYLAND 20785 Approximate Interval Between Onset and Death 23d. Date of delivery Day Year Month 23e. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 XNo 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 2X No 1 □Yes 4 Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 28d. Describe how injury occurred 28f. Location (Street and Number or Rural Route Number, City or Town, State) 1 Crtifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29d. Date signed (Month, Day, Year) **DECEMBER 22, 2009**

State Registrar GODSWILL OKOJI M.D.

31. Date filed (Month, Day, Year,

1809 BENNING ROAD N.E. WASHINGTON, DC 20002

State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ To. Sutton 2009 Margaret December 11:45 AM Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death Calvert County Nursing Center Prince Frederick Calvert 6. Sex 1 \(\text{M} \) 2 \(\text{T} \) F 8. Date of Birth May 25 1916 5. Social Security Number If Under 1 Year If Under 24 Hrs. Funeral 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign Hours 219-26-2824 Pennsylvania Director Usual Residence of Decedent f heath and Mental Hygiene. Item 27 is marked other than "natural", or items 23a or 28a-f show other traumatic event, the Medical Examiner must be notified at filed within 72 hours after death with the Maryland 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director 1 Tes 2 No Maryland Calvert Prince Frederick 10e, Street and Numbe 10g. Citizen of What Country? Funeral Ridge Road United States 604 Tobacco 20678 13. Was Decedent of Hispanic Ongin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 11. Marital Status 14. Race - American Indian, Black, White, etc. 1 Yes 2 No If Yes, Give Year or Dates. þ 1 Never Married 2 Married Maryland 21215-0036 1 ☐ Yes 2 ☐ No Specify: white Specify: Completed 3 X Widowed 4 ☐ Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) clerk retail sales Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) permit. Page 1 and 2 should be file Department of Health and Mental I Important: If item 27 is marked o any injury or other traumatic ever ဂ္ Harvey M Shellenberger Myrtle May Kunkle 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Carl L. Sutton - son 605 Tobacco Ridge Road Prince Frederick MD 20678 Baltimore, 20b. Place of Disposition (Name of cemetery, crematory or other place) Dec. 23 2009 Southern Memorial Gardens 20a. Method of Disposition 20c. Location - City or Town, State 1 X Burial 2 Cremation 3 Removal from State Dunkirk Maryland 4 Donation 5 Other (Specify) 21. Signature of Euperal Service Licensee 22. Name and Address of Facility Rausch Funeral Home, P.A. 4405 Broomes Island Rd., Port Republic, MD 20676 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Immediate Cause (Final disease or condition Onset and Death Physician/ Athero sclenotic Cordio Vescular diseus Medical resulting in death) **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Examiner Due to (or as a consequence of): the Hospital or Attending Physician: The law requires that the death certificate be executed attending physician and for use as the burial-transit that initiated events Due to (or as a consequence of): resulting in death) Last Physician/Medical Box 68760 IF FEMALE 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy
5 ☐ Other (specify) in the past 12 months?
1 Yes 2 No Month Day Year signed by the at the detached for 9 Unknown P.O. Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by Records, Cerebrovasular Accident 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? Yes 2 2 No 1 ☐ Yes 2 ☐ No Division of Vital 25. Was case referred to medical funeral director, Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 🗷 No 1 Yes ပ 1 Inpatient 2 ER/Outpatient 3 DOA this 28a. Date of injury (Month, Day, Year) Certificate: 27. Manner of Death 28b. Time of 28c. Injury at 1 🖸 Natural 5 \square Pending work?
1 Yes 2 No hours after death. Ineral Director: Al 2 Accident
3 Suicide
4 Homicide Investigation 6 Could not be completed filled in by the 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier (Check 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated within 2 To the 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) D. 50653 12-21-2009 yan .C. Jurana. 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) SURDNA GYAN C 10 5851 Muschton Ruad Deale, m.D. 31. Date filed (Month, Day, Year) 32. Registrar's Signature State DEC 22 2009 Registrar

			For State	State o	of Marylar		artment <i>tificate</i>			and M	lental Hy	gien	e 2 N	09	42981
		ы	Registrar 1. Decedent's Name (First, Middle,	Last)		Cei	uncate	ט וט	eam	1	2. Date of De	Reg. N	اه. د 0	0 2	3. Time of Death
	Physicia		Harold Sim	•							Month Decemi		Day	Year	10:00 a M
-	Medic Examin		4a. Facility Name (if not institution,	give street and nun	nber)		4b. City, T	own, or I	Location	of Death	Deceill		lc. County		10:00 a
			3148 Gracefiel	d Road, #	‡5 1 1		Silv	er S	Sprin	ıg					eorge's
	Funeral Director		5. Social Security Number 063 – 09 – 2096	6. Sex 1 🛣 M 2 🗆 F	7. Age (In yrs. 91	last birthday) Yrs.	If Under Months	Year Days	If Under Hours	24 Hrs. Min.	8. Date of Bir (Month, Da Aug.	th y, Year		9. Birthr	place (State or Foreign try) 7 York
	3		Usual Residence of Decedent								Aug.	J, 1	1910	Men	TOTK
	yland f show ed at	ctor	10a. State 10b. County		10c. Ci	ty, Town or Lo	cation							1	0d. Inside City Limits
	e Mar 28a- notifii	Director		rince Geo	rge's	Silv	er Sp		J						1 Yes 2 X No
	with th	Funeral I	10e. Street and Number 3148 Gracefie	ld Road,	#511		10f. Zip (0904	Į			10g. (USA		itry?
	death items ier m		11. Marital Status	12. Was Dece Armed Fo	edent Ever in U.		Vas Decede f Yes, specif	nt of His	panic Ori	igin? (Spe	cify Yes or No-			e - Americ	
36	after or	d by	1 ☐ Never Married 2 ☐ Marr 3 ☐ Widowed 4 ♣ Divorced	ed 1 1 Yes If Yes, Giv	2 □ No re t		Yes 2				noar, etc.,		Specify:	k, White, e	ite
9-	hours natur lical E	lete	15. Deceden	Year or Dat's Education			ient's Usual					16b.	Kind of Bu	_	
21215-0036	nin 72 ne. .han " e Mec	Completed	(Specify only higher Elementary/Seconday (0-12)	College (1		life. D	kind of work O NOT use i	retired)	iring m os	t of workir	ng				,
121	d with Hygier ther t	Be C				Home	Buil		10.11.11	1 11	(FT: 4 A 4: 1 II		nstr		on
lanc	l be file fental F rked o ric eve	70 E	Sam Simon	151)				- 1			(First, Middle, Shkin	Maidei	n Surname	9)	
Maryland	permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f sho any injury or other traumatic event, the Medical Examiner must be notified at once.		19a. Informant's Name/Relationsh Gerald Simon/S			19b. Mailir	ng Address (Street ar	nd Numbe	er or Rurai	Route Numbe	er, City o	or Town, S	tate, Zip C	Code) ID 20878
je,	I and 2 F Health Item 2: other t		20a. Method of Disposition		20b. I	Place of Dispo	sition (Name	e of	- :		late		Location -		
Baltimore,	Page nent o ant: If ury or		1 ☐ Burial 2 ☐ Cremation 4 ☐ Donation 5 ☐ Other (S)		State Me t	ropoli	tan C	ner place, rema	tory		24,			-	Virginia
Balt	permit. Depart Import any inj		21. Signature of Funeral Service Li	censee	<	22	Name and 500 Un	Address Sivel	of Each	llins Blv	Funer	al E	Home lver	Inc. Sprin	ng, MD 2090
			23a. Part 1. Enter the disease, or shock, or heart failure. List or	complications that only one cause on ea	caused the deat	th. Do not ente	er the mode	of dying,	, such as	cardiac o	respiratory ar	rest,			Approximate Interval Between
	Physician/ Medical		Immediate Cause (Final disease or condition resulting in death)		nic Mye		us Le	ukem	ia						Onset and Death
1	Examiner		resulting in deathy	Due to (or as a conseq	uence of):									
72	, ±	iner	Sequentially list conditions, if any, leading to immediate cause Enter Underlying Cause (Disease or iinjury	b. Due to (or as a conseq	uence of):									
D	and errans	Examiner	Cause (Disease or linjury that initiated events resulting in death) Last	c. Due to (or as a conseq	uence of):								-	
09	certificate be executed inding physician and use as the burial-transit	ical	,	d											
6876		Med	IF FEMALE:												
~	th cert ttendii or use	ian/	23b. Was decedent pregnant in the past 12 months?		Birth 2 🗆 Feta	al death 3						- 3		e of delive	
09/03/1918 cords, P.O. Box	he dea y the a	hysic	1 Yes 2 No 9 Unknown	4 ∐ Pregi 9 ☐ Unkr	nant at time of	death 5 L	Other (spe	cify)		-			Moi		Day Year
34/1 P.O.	s that t gned b	by P	Part II. Other significant condition	ns contributing to d	eath but not res	sulting in the u	nderlying ca	use give	n in Part	I.					e cause of death?
3/6 rds,	equire een si ould l	eted		**							-				pably 4 🗆 Unknown
ā	Attending Physician: The law requires that the death r death. stor: After this certificate has been signed by the atte by the funeral director, page 2 should be detached for	Completed by Physician/Medical										psy ormed?	p	Vere autop prior to cor leath?	osy findings available impletion of cause of
1900 Sital B	ian: T	Be C	25. Was case referred to medical examiner?					26. Plac	ce of Dea	th (Check	1 🗌 Yes only one)	2501	70 <u> </u> 1	LJ Yes	2 L NO
عرر Xit	hysic his ce I direc	힏	1 ☐ Yes 2x No		Inpatient 2	ER/Outpatier	t 3 🗆 DO/	Other	: 4 □ Nt	ursing Hor	ne 5 🔀 Resid	dence	6 🗆 Othe	r (Specify)	
	ding P. h. After t	ate:	27. Manner of Death 1 X Natural 5 Pending		of injury th, Day, Year)	28b. Time of injury	280 M	c. Injury a work?			8d. Describe h	now inju	ary occurre	ed	
wo∧, Division	Atten	řţįį	2 Accident Investig 3 Suicide 6 Could r 4 Homicide determi	ot be 28e. Place	of Injury - At ho	me, farm, stre			C3 Z	_				r or Rural	Route Number,
Juno A, Divisio	Hospital or 24 hours afte Funeral Dire sted filled in I	al Ce		buildir	ng, etc. (Specify					9	City or Tov				
S	To the Hospital or Attending Physician: The law requires that the death certific within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending prompleted filled in by the funeral director, page 2 should be detached for use as	Medical Certificate:	(Check 2 L Medical Ex	Physician: To the b caminer: On the bas Nurse Practioner:	is of examinatio	n and/or invest	igation, in m	y opinion	, death o	ccurred at	the time, date a	and plac	e, and due	to the cau	ise(s) and manner stated.
	To the vithin 2 To the comple		29b. Signature and title of certifier Audit	Kenia	lest	_	29c. l	D3 6	number 5716				ate signed ecemb		Day, Year) B , 2009
			30. Name and address of person w Andrew Kundrat	, MD 3	110 Gra	cefiel	d Road	đ, S:	ilve	r Spr	ing, M	D 2	0904		
÷	Stat Registra	C -	31. Date filed (Month, Day, Year) DEC 2 4 2	3. R	egistrar's Signa										

State of Maryland / Department of Health and Mental Hygiene Reg. No. 2 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2 Date of Death **Physician** December [□]1^y9, 2ď⁰9 Schiller 4:20 A M /Medical 4a. Facility Name (If not institution, give street and number) Examiner 4b. City. Town, or Location of Death 4c. County of Death 8100 Connecticut Ave #321 Chevy Chase Montgomery
9. Birthplace (State or Foreign 8. Date of Birth (Month, Day, You July 14, 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** Year) 914 Months Davs Hours Min. 1 □ M 2 👽 F Indiana 306-28-0275 95 **Director** Usual Residence of Decedent filed within 72 hours after death with the Maryland 10a, State 10b. County 10c. City, Town or Location 10d. Inside City Limits 28a-f show r than "natural", or items 23a or 28a-f show the Medical Exeminar must be notified at 1 Yes 2 No Director Montgomery Chevy Chase 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 8100 Connecticut Ave #321 20815 U.S.A. by Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 11. Marital Status 14. Race - American Indian. 1 Yes 2 No
If Yes, GiveX
Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 White 1 ☐ Yes 2 No Specify Specify: 3X Widowed 4 ☐ Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) permit. Pages 1 and 2 should be filed within Department of Health and Mental Hygiene. Important: If item 27 is marked other than "any injury or other traumatic event, the Man Elementary/Secondary (0-12) College (1-4or 5+) 12 Owner Night Club/Entertainment 17. Father's Name (First, Middle, Last) Be 18. Mother's Name (First, Middle, Maiden Surname) Albert. Fe1d Anna Gertrude Brenman ပ္ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Carole Feld/Niece 2556 Massachusetts Ave NW Washington, DC 20008 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State Date 1 ☑ Burial 2 ☐ Cremation 3 ☑ Removal from State 4 □ Donation 5 □ Other (Specify) Mt Sinai Mem. Park 12/27/2009 Los Angeles, CA 21. Signature of Funeral Service Licensee 22. Name and Address of Facile dward Sagel Funeral Direction, INC Green Greenhut M01597 Mellissa 1091 Rockville Pike, Rockville, MD 20852 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Immediate Cause (Final 5 Months Myocardial Infarction **Physician** disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Atrial Fibrillation Years Sequentially list conditions Due to for as a consequence of cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examir Hospital or Attending Physician: The law requires that the death certificate be executed and burial-tra Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760. attending physician Physician/Medical the IF FEMALE 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 - Ectopic pregnancy in the past 12 months? Month Day Year 4 ☐ Pregnant at time of death 5 Other (specify) ☐Yes 21 No the 9 Unknown 9 Unknown þ signed Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Osteoarthritis 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4X Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? Chronic Constipation autopsy certificate performed' 2**√** No 1 ∐Yes 2 🗐 No Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Certification: To 1 ☐ Yes 2 🔀 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA this 28a. Date of Injury (Month, Day, Year) 27. Manner of Death 28b. Time of After 28c. Injury at Work? 28d. Describe how injury occurred Natural 2 Accident 5 Pending investigation Injury 1 ☐ Yes 2 ☐ No I Director; / 3 Suicide 6 ☐ Could not be determined 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 - Homicide within 24 hours aft

To the Funeral Di

completely filled in Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Medical 29a. Certifier (Check only one) within 2 To the 29b. Signature and title of certifier 29c. License number မ 29d. Date signed (Month, Day, Year) U December 21, 2009 30. Name and address of person who completed cause of ceath (Item 23a) (Type, Print) 10810 Darnestown Road Ste 202, Gaithersburg, Maryland 20878 31. Date filed (Month, Day, Year) 32 Registrar's Signature State Registrar

DHMH 17 Rev 1/2001

			1 - State of Maryland / Depa Registrar Cer	rtment of Health tificate of Deat	h and Men th	tal Hygier Reg. I	ne No. 2009	42983
	Physici /Medic		1. Decedent's Name (First, Middle, Last) Norma SCHECHTER			Date of Death Month Cember	20, 2009	3. Time of Death 12:33 A M
The state of the	Examin		4a. Facility Name (If not institution, give street and number)	4b. City, Town, or Location	on of Death		4c. County of Dea	
mand d	Funeval		Holy Cross Hospital 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday)	Silver Spr		Date of Birth	Montgo	nery thplace (State or Foreign
Н	Funeral Director		112-20-0519 1□ M 2X□ F 99 Yrs.	Months Days Hours	Min. Fe	Date of Birth Month, Day, Yea D. 26,	1910 Pe	nnsylvania
	land ow		Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Loc	ation			-	10d. Inside City Limits
;	e Mary la-fsh liffed	ctor	Maryland Montgomery Silver	Spring				1 □ Yes 2 No
	with the	Director	10e. Street and Number	10f. Zip Code			Citizen of What Co	*
	ms 23	Funeral	11013 Childs Street 11. Marital Status 12. Was Degedent Ever in U.S. 13. W	20901	Origin? (Specify		nited Sta	
9800	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hydiene. Important: I filem 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, it is in close for a nust be notified an once.		I 1 Never Married 2 □ Married I 1 □ Yes 2 M□ No	/as Decedent of Hispanic of Yes, specify Cuban, Mexico		n, etc.)	Black, Whit	
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ry I	hould d Men marke matic	ဥ	Stanley Arbaczauskas 19a. Informant's Name/Relationship (Type, Print) 19b. Mailind		Barbara		T	7-0-1-1
, Ma	and 2 sealth an 27 is a ser trau			g Address (Street and Nun Childs Stre	eet, Sil	ver Spr	ing, MD	20901
altimore, Maryland 21215-0036	Pages 1 ament of He ant: If item ury or oth			ition (Name of atory or other place) d Cemetery	Date 12/22/0		Location - City or mont, NY	Town, State
Balt	permit. Depart Import any inj once.			Name and Address of Fac				20012
	hysician /Medical Examiner		23a. Part1. Enter the disease, or complications that caused the death. Do not ente shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Bowel Obstruction Due to (or as a consequence of): Acute Renal Failure		as cardiac or res	wasii ng piratory arrest,	LON, DC	Approximate Interval Between Onset and Death
		Ē	Sequentially list conditions, if any, leading to immediate	е	1110-11-11-11		- 2	
)	ruled transit	Examiner	Sequentially list conditions, if any, leading to instructions cause. Enter Underlying Cause (Disease or injury that initiated events cause) and the sequential death) is established as a consequence of): Non-ST-Segment Electrical Control of the sequence	vation Myoca	ardial I	nfarcti	on	
, e	physician and street transit the burial-transit		resulting in death) Last . Due to (or as a consequence of):					
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ords, P.O. Box	requires institute the death being in been signed by the attending I should be detached for use as	Physician/M		Ectopic pregnancy Other (specify)			23d. Date of de Month	ivery Day Year
S, T	igned I	by P	Part II. Other significant conditions contributing to death but not resulting in the unc	derlying cause given in Par	rt I.	23e. Did tobacc	o use contribute to	the cause of death?
or or	peen s	eted						robably 4 📉 Unknown
VITAL RECORDS,	within 24 hours after death. To the Funeral Director: After this certificate has I completely filled in by the funeral director, page 2 s	e Completed	Hypotension 25. Was case referred to medical			24a. Was an autopsy performed/ 1 □ Yes 2 □N	prior to death?	atopsy findings available completion of cause of
I VI	is cert	To Be	examiner? 1 Yes 2 No Hospital: 1 I Inpatient 2 ER/Outpatient	Other	ace of Death (Ch Nursing Home		6 ☐ Other (Spe	cify)
n or	After th		27. Manner of Death 1 Natural 5 Pending 28a. Date of Injury (Month, Day, Year) 28b. Time of Injury	28c. Injury at Work?	28d.	Describe how in		ony
IVISION	death.	licati	2 Accident investigation 3 Suicide 6 Could not be 230 Bloom of trium. At home form also	M 1 □ Yes 2 [ocation (Street	and Number or Ci	ural Route Number,
בֿיַ בֿלַ	rs after al Dire ed in b	Certification:	4 Homicide determined building, etc. (Specify)	n, tuotory, omeo	201. 6	City or Town, St	ate)	arar noute Number,
he Hosni	in 24 hou he Funer	Medical	29a. Certifier (Check only one) 1 ★ Certifying Physician: To the best of my knowledge, death 2 ★ Medical Examiner: On the basis of examination and/or investant manner stated.	occurred at the time, date estigation, in my opinion, d	e and place, and death occurred at	due to the cause the time, date a	e(s) and manner a and place, and due	s stated. to the cause(s)
Į.	5	2	29b. Signature and title of certifier MD	29c. License numbe 003497	er		Date signed (Mont L2/20/09	h, Day, Year)
			30. Name and address of person who completed cause of death (Item 23a) (Type, P Rupinder Jeet S. Sandhu, M.D., 1500 Fo	orest Glen R	load, Si	lver Spr	ring, MD	20910
Ì	Stat Registra		31. Date filed (Month, Day, Year) DEC 24 2009 32. Registrar's Signature					

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2009 42984 1. Decedent's Name (First, Middle, Last) 3. Time of Death 2. Date of Death Physician 26 2009 John Vincent Seifarth December AL /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner 13911 Sunrise Dr. Maugansville Washington County If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) May 19,1928 5. Social Security Number 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign Funeral Months Days Hours Min. Mary Land May 212-24-1658 Director 81 Usual Residence of Decedent filed within 72 hours after death with the Maryland 10b County 10c. City, Town or Location 10d. Inside City Limits r than "natural", or items 23a or 28a-f show the Medical Examiner must be notified at Director Maryland Washington County Maugansville 1 ☐ Yes 2 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 13911 Sunrise Dr. 21767 U.S.A. Completed by Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 12. Was Decedent Ever in U.S. Armed Forces? 11 Marital Status 1 XYes 2 ☐ If Yes, Give Year or Dates: 1 Never Married 2 Married 2 ☐ No Baltimore, Maryland 21215-0036 1 ☐ Yes 2 XNo Specify: Specify: White 3 Widowed 4 Divorced 15. Decedent's Education (Specify only highest grade completed) Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 7 is marked other than traumatic event, the Me Elementary/Secondary (0-12) College (1-4or 5+) Aeronautical Engineer Aircraft Mfg. 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) permit. Pages 1 and 2 should be file Department of Health and Mental Hy Important: If item Z7 is marked oth any lipiny or other traumatic event 2008. Be Henry Russell Seifarth Cora Madeline Engle Seifarth ပ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Patricia L. Seifarth-wife P.O Box 171 Maugansville, MD 21767 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Salem Reformed Church Cemetery 1 XBurial 2 ☐ Cremation 3 ☐ Removal from State 12-29-2009 | Hagerstown, Maryland 4 □ Donation 5 □ Other (Specify) 22. Name and Address of Facility 1331 Eastern Blvd. North Hagerstown, MD 2 1742 Douglas A. Fiery Funeral Home 21. Signature of Funeral Service Licensee 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** 000 disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to (or as a consequence of) Hospital or Attending Physician: The law requires that the death certificate be executed and Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760. attending physician for use as the buria Physician/Medical yes, outcome of pregnancy

☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy in the past 12 months? Month Year Pregnant at time of death 5 ☐ Other (specify) ☐Yes 2☐No the 9 Unknown 9 Unknown ģ Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? should be 1 ☐ Yes 2 XNo 3 Probably 4 Unknown Completed been 24b. Were autopsy findings available prior to completion of cause of death?
1 □ Yes 2 □ No 24a. Was an has autopsy performe certificate 1 □Yes 2 completely filled in by the funeral director. Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 🗌 Yes 1 Inpatient 2 ER/Outpatient 3 DOA Certification: To this 28b. Time of Injury 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28c. Injury at Work? 28d. Describe how injury occurred After Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No s after death 2 Accident 6 ☐ Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide To the Hospital within 24 hours a To the Funeral D 29a. Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. ical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 3H 19+ 30 Ago 32. Registrar's Signature State Registrar

DHMH 17 Rev 1/2001

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/Medic Examin		4a. Facility Name (If not institution,			,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,	4b. City,	Town, or I	Location of		,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,		County of De		
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and w		Usual Residence of Decedent 10a. State 10b. County		10c. City	y, Town or Lo	ocation							10d. Inside	City Limits
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with the Marylar a or 28a-f show be notified at	Director	10e. Street and Number				10f. Zip	Code				10g. Cit	izen of What	Country?	
filed within 72 hours after death with the Maryland Hygiene. uther than "natural", or items 23a or 28a-f show ent, Ite Medical Examiner must be notified at	alD	800 Sharps Poi	nt Road			21	826					U.S.A	•	
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permit. Pages 1 and 2 should be filed within 72 hours Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "natural", any injury or other traumatic event, Ite Medical Exagonee.		19a. Informant's Name/Relationshi		-)		ing Address Sharp				Route Number Fruitl			e, <i>Zip Code)</i> 21826	
1 and Healtl em 27 ther t		Norma K. Sockr	iter (Wife						Da				or Town, State	
ages int of t: If It		1 X Burial 2 ☐ Cremation 3		e	lace of Dispe emetery, cre			111	ec. 3	0. 2009			aryland	_
nit. Pa artme ortani injury		4 ☐ Donation 5 ☐ Other (Special Support of Funeral Service Li		Spri	inghil 2						пев.	LOII, M	aryranc	
Dep Imp		171	Jewel	U		Short 13 Ea	. Fune .st Gi	eral rove	Home Stree	et Del	mar	, DE	19940	
		23a. Part 1. Enter the disease, or co shock, or heart failure. List o	omplications that cause	ed the death							rest,	-	Approxi	mate Between
Physician		Immediate Cause (Final disease or condition			nom	a C.	0100	7					Onset a	nd Death
/Medical		resulting in death)	Due to (or a											
Examiner	L	Sequentially list conditions,	b											
led sit	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	Due to (or a	s a consequ	uence ot):									
be executed ician and burial-transit	xan	that initiated events resulting in death) Last	c Due to (or a	s a consequ	uence of):								1	
e be sicia	calE		d											
tificate ig phys as the	ledi	8												
eath certific attending p for use as	an/N	IF FEMALE: 23b. Was decedent pregnant	23c. If yes, outcom			☐ Ectopic (oregnancy					23d. Date of		Year
e dea the at sed fo	Physician/Medi	in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown	4 ☐ Pregnant 9 ☐ Unknown	at time of d		Other (s						Month	Day	real
The law requires that the death certifical ate has been signed by the attending phypage 2 should be detached for use as the	Phy	Part II. Other significant condition	s contributing to death	but not resu	ulting in the u	underlying	cause nive	en in Part I		23e. Did to	obacco	use contribute	e to the cause	of death?
signe	d by	Dm 1					g			1 🗆 Y	es 2	□No 3⊡	Probably 4	Unknown
v requ been shoul	Completed	itim								24a, Was	an	24h Were	autopsy findi	ngs available
he lav e has	ршс									autop	rmed?	prior	to completion	of cause of
sician: The law certificate has b rector, page 2 s	Be Co	25. Was case referred to medical						26. Place	e of Death	1 ☐ Yes (Check only o) 1 1 1	res 2□No	
Physici this cer al direct	To B	examiner? 1 ☐ Yes 2 ☐ No	Hospital:	tient 2	ER/Outpatie	ent 3 🗆 D	OA Othe	Vr.		ne 5 Resid		6 ☐ Other (S	Specify)	-
ding Ph h. After th funeral	I:uc	27. Manner of Death 1 Natural 5 Pending	28a. Date of Ir (Month, I		28b. Time Injury	of	28c. Injury Work	at ?	2	8d. Describe h	now inju	ry occurred		
tendii death. tor: A the fu	catio	2 ☐ Accident investiga	ition			М		res 2□						
or Ati fter d Direct in by	Certification:	3 ☐ Suicide 6 ☐ Could no determin	28e. Place of I	njury - At ho etc. <i>(Specif</i>	ome, farm, si <i>y)</i>	treet, factor	y, office		2	8f. Location (8 City or Tov	Street ar vn, State	nd Number oi e)	r Rural Route i	Number,
Hospital or Attending Physiclan: 24 hours after death. Funeral Director: After this certifica etely filled in by the funeral director, p		29a. Certifier 1 Certifying	Physician: To the be	st of my kno	wledne dea	ith occurred	at the tim	ne date a	nd place a	and due to the	cause(s	s) and manne	r as stated	
24 hc 24 hc Fun etely	Medical		xaminer: On the basis and manner	of examina										se(s)
To the Hos within 24 h To the Fun completely	Me	29b Signature and title of certifier		1			c. License			T	29d. Da	ite signed (M	onth, Day, Yea	ır)
. 0			1	\rightarrow		1	454	823	7		12	2/28	109	
Was	6	30. Name and address of person	(ho completed cause of	death (Iten	1 23a) (Type	Print)	OIKI	£.0	200	SUITE I	103	SALA	SBNZZ	N
1/4		31 Date filed (MOVE 1997)	30 Rania	strar's Signs	ture	1		- 4					ZiED	1
Sta Registr		31. Date filed (MUEC) 29	2009 Zaya	Mar o Gigila	ture de	ark								

DHMH 17 Rev 1/2001

		1 - State Registrar Amend Item 1. Decedent's Name (First, Middle, Lasi			Cer	tificate of t	Death	2. Date of Dea		005	4 2 9 8 (
Physici /Medic		, , ,	na J. Sh	ew				Month	Day	00 ^{Year}	4:15 am
Examir 	ner	4a. Facility Name (If not institution, give Holly Place 5. Social Security Number 6. Se	x 7.	er) Age (In yrs. las	st birthday)	Hagers	If Under 24 Hrs.	8. Date of Birth	Wa	shingt 9. Birthp	lace (State or Foreig
irector		210-26-9956 1 Decedent	M XXF	79	Yrs.	Months Days	Hours Min.	(Month, Da 05-29	-1930	Pen	nsylvania
show	ō	10a. State 10b. County		10c. City,	Town or Loc					1	0d. Inside City Limits
r 28a-i	Director	MD Washing 10e. Street and Number	on		над	erstown 10f. Zip Code			10g. Citizen o	of What Cour	
23a o		268 S. Potomac S	reet			21740			USA		
of other than "natural", or items 23a or 28a-f show event, the Madical Eva-ciner must be notified at	by Funeral	11. Marital Status 1 ☐ Never Married 2 ☐ Married 3 ☑ Widowed 4 ☐ Divorced	12. Was Decedel Armed Force 1 ∐Yes 2 [If Yes, Give Year or Date:	s? XINo		Vas Decedent of Hi iYes, specify Cuba □Yes 2⊠No	spanic Origin? (Spin, Mexican, Puerto Specify:	ecify Yes or No- Rican, etc.)	14. R B	ace - Americ lack, White, e cify: wh	
than "natur Redical	Completed	15. Decedent's Edu (Specify only highest grace Elementary/Secondary (0-12)	cation e completed) College (1-4a		(Give l life. E		ation luring most of worki)	ng	16b. Kind of		dustry
is marked other thraumatic event, the	Be Co	17. Father's Name (First, Middle, Last)			Hous	ekeeping 	18. Mother's Name	(First, Middle,		lege ame)	
irked o	To B	Willis Frey					Elizab	eth Pax	ton		
		19a. Informant's Name/Relationship (7) Michael R. Shew	rpe. Print) (son				and Number or Rura one Hill				^{Code)} PA. 1720
5 E I		20a. Method of Disposition 13 Burial 2 ☐ Cremation 3 ☐ f 4 ☐ Donation 5 ☐ Other (Specify)	_	cen	netery, crem	sition (Name of latory or other place Memoria		2/16/09	20c. Location	•	wn, State urg, PA.1
Important: If any injury o		21. Signature of Juneral Service Lio	M013	46	2	Name and Addres 3 FA11ing	s of Facility The SPring				ral Home A 17202
bhysician and prize transit the burial-transit	cal Examiner	disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause from the conditions of the cond	Due to (or a	as a consequer as a consequer	nce ett.					-11	
attending for use as	Physician/Medical	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown		n 2 ☐ Fetal de tat time of dea	eath 3	Ectopic pregnancy Other (specify)	,			Date of delive	ery Day Year
s been signed by the should be detached	þ	Part II. Other significant conditions co	ntributing to death	but not resulti	ng in the un	derlying cause give	en in Part I.				ne cause of death? eably 4 🗌 Unknow
# CI	Completed							24a. Was a autop perfor	rmed?	b. Were auto prior to co death? 1 ☐ Yes	psy findings available mpletion of cause of
To the Funeral Director: After this certificate he completely filled in by the funeral director, page	Certification: To Be	25. Was case referred to medical examiner? 1 Yes 2 No 27. Manner of Death 1 Natural 5 Pending investigation 3 Suicide 6 Could not be determined	28a. Date of In (Month, I	Day, Year)	8b. Time of Injury	28c. Injury Work	4 □ Nursing Ho / at / es 2 □ No	me 5 Resid	dence 6 000 now injury occ	urred	y) 7LJ+ L
the Funer mpletely fill	Medical (29a. Certifier (Check only one) 1 Certifying Phy 2 Medical Exami	sician: To the be- ner: On the basis and manner	of examinatio	edge, death n and/or inv	estigation, in my o	oinion, death occuri	ed at the time,	date and plac	e, and due to	the cause(s)
P 00	2	29b. Signature and title of certifier	Z	. (111	29c. License	06323		29d. Date sign	ned (Month,	
5		30. Name and address of person who co	Ave A) 217	42		-	

			For State	State of Marylan	d / Depa	artment of I	Health and	Mental Hy	giene	9 42987
			Registrar 1. Decedent's Name (First, Middle, Last))	Cei	tificate of l	Death	2. Date of De	Reg. No. 200	3. Time of Death
	Physicia Medio		KADIATU	TURAY				Month DECEME	Day Yea	r
	Examin		4a. Facility Name (if not institution, give s HOLY CROSS HOSPIT	· ·			r Location of Deat		4c. County of Do	
	Funeral		Social Security Number 6. Sex	7. Age (In yrs. Ia		If Under 1 Year Months Days	If Under 24 Hrs Hours Min.			Birthplace (State or Foreign
	Director		240-83-0290 Usual Residence of Decedent	38	Yrs.			MAY 1	1971 SI	ERRE LEONE
	yland -f shov ed at	ctor	10a. State 10b. County		, Town or Lo	cation				10d. Inside City Limits
	he Mar or 28a e notifi	Dire	MD PRINCE GE 10e. Street and Number	CORGE'S BO	WIE	10f. Zip Code			10g. Citizen of What	12 Yes 2 No
	s 23a oust be	Funeral Director	1217 KINGS TREE D	DRIVE		20721			USA	ooundy?
9	if flied within 72 hours after death with the Manyland tal Hyglene. ad other than "natural", or items 23a or 28a-f show event, the Medical Examiner must be notified at		11. Marital Status 1 ☑ Never Married 2 ☐ Married	12. Was Decedent Ever in U.S Armed Forces? 1 ☐ Yes 2 ☒ No		Vas Decedent of H	in, Mexican, Puerl	pecify Yes or No- o Rican, etc.)	Black, Wi	
21215-0036	ours aff itural", al Exa	Completed by	3 Widowed 4 Divorced	If Yes, Give Year or Dates.		☐ Yes 2 X No			Specify: I	BLACK
215-	n 72 hc s. an "na Medic	mple	15. Decedent's Edu (Specify only highest grad Elementary/Seconday (0-12)		(Give	ient's Usual Occup kind of work done (O NOT use retired)	ation during most of wo	rking	16b. Kind of Busines	ss Industry
121	ed within Hygiene. other tha ent, the I	Be Co	12th		NURS	SE	-		PRIVATE	
Baltimore, Maryland	should be filed h and Mental Hy 7 is marked oth traumatic event	P B	17. Father's Name (First, Middle, Last) SHINNEH KAMARA					me (First, Middle, 'A KARGI	Maiden Surname) 30	
Man	of and 2 should be of Health and Ment fitem 27 is marked rother traumatic e		19a. Informant's Name/Relationship (Typ	e, Print)					er, City or Town, State,	
re,	and 2 f Health item 27 other tr		JIMMY KAWA/FRIENI 20a. Method of Disposition	20b. Pl	ace of Dispo	sition (Name of		BOWLE,	MARYLAND 20 20c. Location - City	
imo	Page nent o ant; If ury or		1 ☐XBurial 2 ☐ Cremation 3 ☐ F Donation 5 ☐ Other (Specify)	Removal from State CAT		atory or other place	· .		•	RING, MARYLAND
Balt	permit. Page 1 Department of I Important: If it any injury or or once.	(21. Signature of pay Solice License	е	22	. Name and Addre	ss of Facility	. B. JE	NKINS FUNE VER,MARYLA	RAL HOME
			23a. Part 1. Enter the disease, or complishock, or heart failure. List only one	ications that caused the death						Approximate Interval Between
	Medical	10	Immediate Cause (Final disease or condition resulting in death)	METASTATI Due to (or as a consequence)		PHOMA				Onset and Death
The second	Examiner		Sequentially list conditions	SELSIS	ence oi);					
	sit sit	Examine	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or linjury	Due to (or as a consequent						
	cate be executed physician and sthe burial-transit	Exa	that initiated events resulting in death) Last	Due to (or as a consequent						
09	ate be e hysicia the bur	dical		d						
687	certifica nding p	n/Me	IF FEMALE: 23b. Was decedent pregnant 25	3c. If yes, outcome of pregnar					23d. Date of	delivery
. Box 687	Attending Physician: The law requires that the death certificate ar death. ector. Adath. ector. Attent this certificate has been signed by the attending phy. by the funeral director, page 2 should be detached for use as the	Physician/Me	in the past 12 months? 1 ☐ Yes 2 ☑ No 9 ☐ Unknown	1 ☐ Live Birth 2 ☐ Fetal 4 ☐ Pregnant at time of do 9 ☐ Unknown		Ectopic pregnand Other (specify)	;y 		Month	Day Year
Division of Vital Records, P.O.	is that th gned by be detak	by	Part II. Other significant conditions con RESPIRATORY FAIL		Ilting in the u	nderlying cause giv	en in Part I.			to the cause of death?
ords	require been s should	leted	RESTERATORT THE					1 🗆 24a. Was		Probably 4 Unknown
Весс	The law cate has page 2 s	Completed						auto	prior t prmed? death	o completion of cause of
ital	ician: The certificate rector, pag	Be	25. Was case referred to medical examiner?	ospital:		26. Pl	ace of Death (Che		- Z/C2 110	
of V	Attending Physician: or death. octor: After this certific by the funeral director,	e: To	27. Manner of Death	1 Inpatient 2 I	28b. Time of	28c. Injur	4	1	dence 6 Other (Sp	ecify)
ion	tendin leath. tor: Aft the fur	Certificate:	1 X Natural 5 ☐ Pending 2 ☐ Accident Investigation 3 ☐ Suicide 6 ☐ Could not be	(Month, Day, Year)	injury		Yes 2 No			
Divis	al or Attenos after deat al Director:		4 Homicide determined	28e. Place of Injury - At hor building, etc. (Specify)	ne, farm, stre	et, factory, office		28f. Location (S City or Tow	Street and Number or F vn, State)	Rural Route Number,
	To the Hospital or A within 24 hours after To the Funeral Dire completed filled in b	Medical	(Check 2 ☐ Medical Examine	cian: To the best of my knowle er: On the basis of examination Practioner: To the best of my	and/or invest	gation, in my opinio	n. death occurred	at the time, date a	ind place, and due to th	e cause(s) and manner stated.
	To the vithin To the comp	2	29b. Signature and title of certifier	Traditional to the past of my	Milowicago, c	29c. License			29d. Date signed (Mo	
			Kshaw	a cong		D 60	826		DECEMBER	23 2009
12	6		30. Name and address of person who con KSHAMA GARG M.D.	mpleted cause of death fitem: 1500 FOREST	23a) (Type, P GLEN F	OAD SILV	ER SPRIN	G,MARYLA	AND 20910	
-	Stat Registra		31. Date filed (Month, Day, Year) DEC 2 9 2009	32. Registraris Signatu						

7/24

State Registrar 30-Name and address of person who completed cause of death (Item 23a) (Type, Print) 10810

32. Registrar's Signature

W

TOWN ROad St. 202

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 🛴 1. Decedent's Name (First, Middle, Last) 2. Date of Death Day 26 2009 **Physician** Month LUMCY /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Bellmore
Under 1 Year If Under 24 Hrs. Universi - Mory laure If Under 1 Year 5. Social Security Number 6 Sex Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) Date of Birth (Month, Day, Year) 464-90-6336 Days 1**⊠**M 2□ F 5 Nebraska 815/1951 Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Maryland|Washington County Director 1 ☐ Yes 2X No Hagerstown 10f. Zip Code 10g. Citizen of What Country? 13434 Keener Rd. 21742 U.S.A. Funeral 12. Was Decedent Ever in U.S. Armed Forces?

1 XYes 2 No 970If Yes, Give
Year or Dates: 1976 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Black. White, etc. 1 ☐ Never Married 2 X Married 1∐Yes 2∭XNo Completed by Specify: White 3 Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NQT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Telephone Repairman 12 Telephone Company 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Eugene I. Turney 0 May Louise Mason Turney 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Deborah Turney-wife 13434 Keener Rd. Hagerstown, MD 21742 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 1 ☐ Burial 2 X Cremation 3 ☐ Removal from State Smithsburg Crematory 12-29-2009 | Smithsburg, Maryland 4 Donation 5 Dother (Specify) 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Douglas A. Fiery Funeral Home 1331 Eastern Blvd. North Hagerstown,MD 21742 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Due to (or as consequence f): Sequentially list conditions, if any, reading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Physician/Medical Examiner resulting in death) Last Due to (or as a consequence of) IF FEMALE: 23c. If yes, outcome of pregnancy

1 Live birth 2 Fetal death
4 Pregnant at time of death 23b. Was decedent pregnant in the past 12 months? 23d. Date of delivery 3 Ectopic pregnancy Month Dav Year 5 Other (specify) 1 □Yes 2 □ No. 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 📉 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? Yes 2 No 2 🗆 No 1 ☐ Yes Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify, Hospital: 1 ☐ Yes 2 🔀 No 1 Inpatient Certification: To 2 ER/Outpatient 3 DOA 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred

/Medical Examiner To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit Division of Vital Records, P.O. Box 68760,

Physician

Funeral

Director

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural" or items 23a or 28a-f show any Injury or other traumatic event, the Medical Examinating the market angular on once.

Baltimore, Maryland 21215-0036

1 🔀 Natural 2 Accident

5 Pending investigation 6 ☐ Could not be

28a. Date of Injury (Month, Day, Year)

1 ☐ Yes 2 No

St. Baltimore MD 21201

29a Certifier (Check only one)

3 Suicide

4 Homicide

Ecrtifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated

Greene

29c. License number

29b. Signature and title of certifier

Lenvoic

MD 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

1314080450

29d. Date signed (Month, Day, Year)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

WH 11+1 Hassam

Medical

31. Date filed (Month, Day, **DEC 30**

32. Registrar's Signature

MD

Registrar DHMH 17 Rev 1/2001

To the Hospital within 24 hours a To the Funeral D

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar item 10b,12/28/09, per F.H., Certificate of Death D.H. WCHD Amended 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month IRMA JEAN TRUITT 20embea Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death MODICAL SAUSBUM HICOMICO REGIONAL If Under 1 Year If Under 24 Hrs. 8. Date of Birth **Funeral** Age (In vrs. last birthday 9. Birthplace (State or Foreign 1 □ M 2 🗓 F Days Min 5-21-1943 Months MARYLAND Director 216-40-3815 66 Yrs Usual Residence of Decedent or 28a-f show notified at 10a. State 10b. County Wicomico 10c. City, Town or Location 10d. Inside City Limits Director MARYLAND | WORCESTER WILLARDS 1 X Yes 2 No 10e. Street and Number Situan commission and the state of the state 10f. Zip Code 10g. Citizen of What Country? Funeral 7398 MAIN STREET 21874 US 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Black, White, etc. þ 1 Never Married 2 X Married Yes 2 XNo Maryland 21215-0036 If Yes, Give Year or Dates 1 Tes 2 X No Specify: WHITE 3 Divorced 4 Divorced Specify Completed injury or other traumatic event, the Medical 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) NURSING ASSISTANT HEALTHCARE Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname, ည HOMER DENNIS ELIZA FISHER permit. Page 1 and 2 should be Department of Health and Men Important: If item 27 is marke any injury or other traumatic 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) EDWARD F. TRUITT/HUSBAND 7398 MAIN STREET, WILLARDS, MD. 21874 Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place, 20c. Location - City or Town, State 1 X Burial 2 Crema 3 Removal from State 4 Donation 5 Dother (Specify) DENNIS CEMETERY 12-24-09 WILLARDS, MARYLAND 22. Name and Address of Facility
MELSON FUNERAL SERVICES, LT
FRANKFORD, 21. Signature of Funeral 23a. Part 1. Enter the disease, it complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. Lift only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ Dreumema disease or condition Medical resulting in death) Due to (or as a consequence on: Examiner Oher Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examiner Due to (or as a consequence of) or Attending Physician: The law requires that the death certificate be executed Cause (Disease or linjury that initiated events 110 -tran and Due to (or as a consequence of) resulting in death) Last g physician a street burial-Physician/Medical P.O. Box 68760 attending p IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy
5 Other (specify) ____ in the past 12 months?

1 Yes 2 No Pregnant at time of death ned by the a Unknown 9 Unknown Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ been signe should be Division of Vital Records, 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed Were autopsy findings available prior to completion of cause of death? 24a. Was an page 2 s autopsy 1 Yes 1 ☐ Yes 2 ☐ No 25. Was case referred to medical Be 26. Place of Death (Check only one) 1 ☐ Yes 2 🔼 No Certificate: To 4 \square Nursing Home 5 \square Residence 6 \square Other (Specify) 1 Inpatient 2 🗌 ER/Outpatient 3 DOA After this filled in by the funeral 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1. Natural 5 Pending 24 hours after death Funeral Director: A 1 ☐ Yes 2 ☐ No Investigation Could not be Accident Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined City or Town, State) To the Hospital Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier соmpleted 2 | Medical Examiner: On the basis of examination and/or investigation, in rity opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. within 2 only one) 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) 09 MO 20 D54127 12 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) BA 5 21804 100 31. Date filed (Month, Day, Year) 32. Registrar's Signatur State ank

DHMH 17 Rev 7/2009

Registrar

		•	for State Registrar		State of Ma	arylan			nt of H e of D		and N	Mental H		ne No. 20(9	42991
	Physicia Medic		1. Decedent's Name (First, Mid Jamshid		^{st)} Vassef					-		2. Date of D Month Decem		^D a ^y 5, 2Č	09	3. Time of Death 5:51 P M
	Examir		4a. Facility Name (if not institut					· ·	, Town, or I		of Death		4	4c. County of		
هدين .	Funeral		Shady Grove 5. Social Security Number	Hos I 6. S		a (In vrs Is	ast birthday)		ockvi	11e	r 24 Hrs.	8. Date of B	lirth	Monte		ry lace (State or Foreign
	Director		213-88-4619		M 2 □ F	68		Months		Hours	Min.	(Month, D	Day, Year 1	941	Coun	
	and show lat	ō	Usual Residence of Decedent 10a. State 10b. Cour	ity		10c. City	y, Town or Loc	ation							1	Od. Inside City Limits
	Maryl 28a-f otifiec	Funeral Director	Maryland Mont	gom	ery	(Gaithe	rsbui	rg							1 ☐ Yes 2 🔀 No
	h the	al D	10e. Street and Number					10f. Zi	p Code				10g.	Citizen of Wha	at Coun	try?
	ath will	uner	10813 Arrowsm:	Lth	Court 12. Was Decedent E	vor in 11 C	2 12 1	Van Dana	2087		ining (C-	:6: \/ \/-		ited S		
36	permit. Page 1 and 2 should be filed within 72 hours after death with the Manyland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.	by	11. Marital Status 1 Never Married 2 N		Armed Forces? 1 Yes 2 1		If	Yes, spe	cify Cuban	, Mexicar	n, Puerto	ecify Yes or No Rican, etc.))-	14. Race - Black, 1	White, e	etc.
Ş	atural	eted	3 Widowed 4 Divord		Year or Dates.		16a. Deced				•		Lan	Specify: C		
215	in 72 h e. nan "n Medi	Completed	(Specify only high	ghest gra	ade completed) College (1-4 or 5	+)	i (Give k	and of wo NOT us	rk done du	iring mos	it of work	ing	166.	Kind of Busir	iess Ind	lustry
7	d withi	Be Co				4	Bus	ines	s Own					Ar	t	
land	l be file fental H rked of tic ever	To B	17. Father's Name (First, Middle Abdollah	, Last)	Vassef				ľ	18. Moth Lai		e (First, Middle V.a.	e, Maide ssef			
lary	should and N is ma auma		19a. Informant's Name/Relatio									al Route Numb	er, City	or Town, State		
e, r	and 2 Health em 27 ther tr		Esmat Vassef/S	pou	se	Took B	-			th C		; Gait				
mor	age 1 ient of l nt: If it		1 Burial 2 Crematic 4 Donation 5 Othe	on 3 ⊑	Removal from State	C	lace of Disposemetery, crem Linco	atory or o	other place)			Date 28/09		Location - Cit	•	wn, State aryland
Baltimore, Maryland 21215-0036	sermit. F Separtm mporta iny inju		21. Signature of Funeral Service			110.	22.	. Name ar	nd Address	of Facilit	ty Sir	nple Tr	ibu	te		-
	00= 60	[6]	23a Part 1. Finier the disease	or com	plications that caused	the death						; Rock		e, MD	208.	
	Physician/	100	23a. Part 1. Enjer the disease, shock, deneart failure. Lis Immediate Cause (Final disease or condition	t only o	ne cause on each line. Hepatic			THE IIIO	ie or dyllig,	, such as	cardiac	or respiratory a	arest,			Approximate Interval Between Onset and Death
	Medical Examiner		resulting in death)		Due to (or as a	consequ	ence of):	7							\top	
		iner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying	J	b. Gastrois Due to (or as a			oleec	h						+	
)	ecuted and -transit	Examiner	Cause (Disease or linjury that initiated events resulting in death) Last	1	c. Due to (or as a	consequ	ence of									
0	e be ex ysician e burial	edical E	roodking in deathy East	L	d	conocqu										
68760	tificate ng phy as th		IF FEMALE:	1												
9 X	ath cer attendi for use	cian/	23b. Was decedent pregnant in the past 12 months?	1	23c. If yes, outcome of 1 ☐ Live Birth 2 4 ☐ Pregnant at	2 🗌 Fetal	Ideath 3 🗌	Ectopic Other (sa					1	23d. Date o		ry Day Year
Ğ.	the de	Physician/M	1 Yes 2 No 9 Unknown	\perp	9 Unknown	time or u	leatii 5 🗆	Other (S)	Jecny)							
л. О	es that igned I be det	þ	Part II. Other significant cond	tions co	ontributing to death bu	t not resu	ulting in the ur	nderlying	cause giver	n in Part	I.					e cause of death?
spic	require been s should	leted														ably 4 🛣 Unknown
ည္သ	ne law te has l age 2 s	Completed										perf	opsy formed?	prio deat	to con	sy findings available pletion of cause of
a	ian; Ti rtifical ctor, po		25. Was case referred to medic examiner?	al I					26. Plac	e of Deat	th (Check	1 🔀 Yes	2 📙 I	Nol 1L	Yes :	2 🔀 No
Ž	hysic this ce at direc	မ	1 ☐ Yes 2 🔀 No	177			ER/Outpatient	3 🗆 D	Other:	4 □ Nu	ursing Ho	me 5 🗆 Res	idence	6 Other (S	pecify)	
Division of Vital Records, P.O. Box	nding Fath. the After to funera	Certificate:	27. Manner of Death 1 X Natural 5 Penical Investigation	ding stigation	28a. Date of injury (Month, Day,	Year)	28b. Time of injury	M 2	8c. Injury a work? 1 🔲 Ye	at es 2□	- 1	28d. Describe	how inju	iry occurred		
Visio	or Atter	Sertif	3 Suicide 6 Cou			y - At hor (Specify)	me, farm, stree	et, factory	, office		\dashv	28f. Location City or To			Rural I	Route Number,
Ō	To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director, After this certificate has been signed by the attending physician and completed filled in by the funeral director, page 2 should be detached for use as the burial-transit	Medical C	29a. Certifier 1 🗓 Certifyi	ng Phys	sician: To the best of n	ny knowle	edge, death o	ccured at	the time, d	late and ;	place, an	d due to the c	ausels) a	and manner a	s stated	i.
	thin 24 the Fu	Mec	(Check 2 □ Medica	ng Nurs	ner: On the basis of ex- e Practioner: To the b	amination	and/or investig	gation, in eath occur	my opinion, rred at the t	, death oc ime, date	courred at	the time date	and plac he cause	e, and due to e(s) and manne	the causer as sta	se(s) and manner stated. ted.
	5		Can Illi	11	holle	M	0	290	License n					ate signed (M cember		•
	~	ŀ	30. Name and address of person	n who c	uc	, .	1	int)			`		76	CCHIDEL	1.7	, 2007
			Jamelle Willia		M.D. 990				r Dri	ive;	Roc	kville,	MD	20850		
	Stat Registra	_	31. Date filed (Mönth, Day, Year)		32 Registrar	s Signati	gear	RI								

			for State Registrar	State of Mary	land / De <i>C</i>	partment of F Certificate of	Health and N <i>Death</i>	Mental Hy	rgiene 2	009	42	992
ı	Physic /Medi		1. Decedent's Name (First, Middle, Last Jerome Weinstock)				2. Date of De Month	Day	Year 2009	3. Time of 3:25	Death P M
A.	Examir		4a. Facility Name (If not institution, give The Casey House	street and number)			r Location of Death	Decemb	4c. Count	y of Death		
	Funeral Director		5. Social Security Number 6. Se	X 7. Age (in In	yrs. last birthd 86	Months Davs	If Under 24 Hrs. Hours Min.	8. Date of Bir (Month, Date 9/13/	rth a <i>y, Year)</i>	9. Birthp Coun	lace (State or	r Foreign
	Maryland I-f show	tor	10a. State 10b. County MD Montgom		. City, Town or					10	Od. Inside Cit	
,	with the	al Director	MD Montgom 10e. Street and Number 15100 Interlachen	"		ver Spring	<u> </u>		10g. Citizen of	What Coun	try?	
36	s 1 and 2 should be filed within 72 hours after death with the Maryland of Heath and Mental Hygiene. Item 27 Is marked other than "natural", or items 23a or 28a-f show other traumatic event, the Widden Evan and Trust be notified at	by Funeral	11. Marital Status 1 Never Married 2 Married 3 Widowed 4 Divorced	12. Was Decedent Ever in Armed Forces? 1X Yes 2 No If Yes, Give 1943 Ye ar or Dates:	in U.S. 1	20906 3. Was Decedent of H If Yes, specify Cuba 1 □ Yes 2ば No	lispanic Origin? (Sp an, Mexican, Puerto Specify:	ecify Yes or No Rican, etc.)	USA 14. Ra Bla Specifi	ce - America ck, White, e		-
Baitimore, Maryland 21215-0036	vithin 72 hou sne. .han "natura .m.dical E	Completed	15. Decedent's Edu (Specify only highest grad Elementary/Secondary (0-12)	cation e completed) College (1-4or 5+)	(G.	cedent's Usual Occup ive kind of work done of e. DO NOT use retired	during most of work d)	ing	16b. Kind of B	Wh:		
lang z	ld be filed w lental Hygie ked other t ic event, th	To Be Co	17. Father's Name (First, Middle, Last) Sidney Weinstock	4	Off	ice Manage	18. Mother's Name		Clothi , Maiden Surnar		nufact	uring
, Mary	and 2 should be t eatth and Mental n 27 Is marked o ier traumatic eve	ř	19a. Informant's Name/Relationship (T) Lawrence Weinstock		1	ailing Address (Street		al Route Numb			Code)	
Imore	0		20a. Method of Disposition 1 M Burial 2 ☐ Cremation 3 ☐ F 4 ☐ Donation 5 ☐ Other (Specify)	20 lemoval from State	b. Place of Dis cemetery, c	sposition (Name of rematory or other place	ce)	Date	20c. Location		wn, State	
Dall	permit. Pag Department Important: I any injury o	ļ,	21. Signature of Funeral Service License	MO1477		22. Name and Addres Edwa 1091 Rockv	ss of Facility ard Sagel ille Pike	Funera Rockvi	l Direc	tion	2	
	Physician /Medical Examiner		23a. Part 1. Enter the disease, or complishock, or heart failure. List only or immediate Cause (Final disease or condition resulting in death)	le cause on each line.	Stroke	enter the mode of dyin	ng, such as cardiac o	or respiratory a	rrest,		Approximate Interval Betw Onset and D	/een
	imcate be executed g physician and as the burial-transit	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Clasace or injury that initiated events resulting in death) Last	Due to (or as a con:								
יים אסר טטי.		Physician/Medical	in the past 12 months?	3c. If yes, outcome of pre 1 □ Live birth 2 □ F 4 □ Pregnant at time 9 □ Unknown	etal death	B ☐ Ectopic pregnancy	/			te of deliver	,	e ar
	e law requires that the d has been signed by the le 2 should be detached	ρ	9 ☐ Unknown Part II. Other significant conditions con		resulting in the	underlying cause give	en in Part I.	1	obacco use cont ⁄es 2 □ No			
וימו וופכל	rtificate has be tor, page 2 sho	e Completed	25. Was case referred to medical				26. Place of Death	1 □ Yes	osy rmed? 2XINo	Were autop prior to com death? 1 □ Yes 2	sy findings av pletion of car 2 No	vailable use of
or Attending Physician	The transplant of Attenting Trystotan. The law requires that the death cert find 4 hours after death. the Funeral Director: After this certificate has been signed by the attending mpletely filled in by the funeral director, page 2 should be detached for use a majetiely filled in by the funeral director.	Certification: To B	examiner? 1 Yes 2 No 27. Manner of Death 1 No Natural 5 Pending investigation 3 Suicide 6 Could not be determined	28a. Date of Injury (Month, Day, Year 28e. Place of Injury - A building, etc. (Spa	er: 4 □ Nursing Hor vat ? /es 2 X No	me 5 ☐ Resid 28d. Describe h	dence 6 X Oth	red	•			
I chicooli or	within 24 hours after To the Funeral Dir completely filled in	edical Ce	29a. Certifier (Check only one) 1 Certifying Phys 2 Medical Examin	ician: To the best of my ler: On the basis of examand manner stated.	knowledge, de ination and/or	ath occurred at the tim investigation, in my op	ne, date and place, a pinion, death occurre	and due to the ed at the time,	cause(s) and madate and place,	anner as sta and due to t	ated. the cause(s)	
5	O Solg thinking		29b. Signature and title of certifier \$\hat{J}\$ ICOUCLE \$\hat{C}\$	hou, m	D	29c. License	_		29d. Date signed			
	Stat Registra	e	30. Name and address of person who con Jocelyne Kouatcho 31. Date filed (Month, Day, Year) DEC 2 2 2009		Muncat	er Mill Ro	l. Rockvi	lle, MD	20855			

		1 - For State Registrar	State of Maryland		artment of Ho tificate of L			giené Reg. No.	2009	
Physici /Medic		1. Decedent's Name (First, Middle, Last) Thomas Benjamin W	estcott, JR.				2. Date of De	ath 1/Day	2009 ^{Year}	3. Time of Death 7:00PM M
Examir		4a. Facility Name (If not institution, give s 3245 Betheden Chu			4b. City, Town, or Pocomoke	or Location of Death ke City 4c. County of Death Worcester				
Funeral Director		770 22 0307 21	M 2□F 7. Age (In yrs. I	ast birthday) Yrs.	If Under 1 Year Months Days	If Under 24 Hr Hours Mir		th (29°)	Birthplace (State or Foreigr Country) Missouri	
B Maryland a-f show	ctor	Usual Residence of Decedent		moke (10d. Inside City Limits 1 ☐ Yes 🎢 ☐ No
h with the 23a or 28	al Director	10e. Street and Number 3245 Betheden Chu			10g. Citiz	en of What Cou USA	ntry?			
s 1 and 2 should be filed within 72 hours after death with the Maryland if health and Mental Hygiene. If the azi is marked other than "natural", or items 23a or 28a-f show other traumatic event, the Medical Examinations to notified a	by Funeral	11. Marital Status 1 Never Married 2	1 P¥Yes 2 □ No		Was Decedent of His f Yes, specify Cubar 1 ☐ Yes 2 🕅 No	spanic Origin? (n, Mexican, Pue Specify:	Specify Yes or No into Rican, etc.)	1	14. Race - American Indian, Black, White, etc. Specify: White	
d within 72 ho giene. er than "natur.	Completed	15. Decedent's Educ (Specify only highest grade Elementary/Secondary (0-12)					orking	g Parks and Recreatio		
Mental Hygi Mental Hygi arked other atic event, t	To Be Co	17. Father's Name (First, Middle, Last) Thomas Benjamin Westcott, Sr. 18. Mother's Name (First, Middle, Mail Ruth Walker						Maiden :	den Sumame)	
and 2 shousaith and N		19a. Informant's Name/Relationship (Type, Print) Mary Patton Westcott/ Wife 19b. Mailing Address (Street and Number or Rural Route Number, Co. 3245 Betheden Church Road, Pocc							omoke City, MD 21851	
permit. Pages 1 Department of He Important: If iter any injury or oth		20a. Method of Disposition 1 Burial 2 □ Cremation 3 □ R 4 □ Donation 5 □ Other (Specify)	Betneden lilgnman Hill 12/24/09					20c. Location - City or Town, State Pocomoke City, MD Funeral Home, P.A.		
Departing Depart		21. Signature of Funeral Service License	Dean	1	07 Vine S	treet,	Pocomoke	city	, MD 21	.851
Physician /Medical Examiner		23a. Part1. Enter the disease, or complishock, or heart failure. List only on Immediate Cause (Final disease or condition resulting in death)	e cause on each line. Charbara Caused the death	obstru					-	Approximate Interval Between Onset and Death
icate be executed physician and sthe burial-transit	Ical Examiner	Sequentially list conditions, if any, leading to immediate cause. East Unoring Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): C. Due to (or as a consequence of):								
death certif e attending d for use as	Physiclan/Medic	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown 23c. If yes, outcome of pregnancy 1 □ Live birth 2 □ Fetal death 3 □ Ectopic pregnancy 4 □ Pregnant at time of death 5 □ Other (specify)							23d. Date of delivery Month Day Ye	
The law requires that the ate has been signed by the page 2 should be detached.	by	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco							o use contribute to the cause of death? 2 □ No 3 □ Probably 4 ☑ Unknown	
The lay ate has page 2	Completed						24a. Was auto perfo 1 Yes	osy ormed?	24b. Were autoprior to condeath?	opsy findings available ompletion of cause of
Physician: Tribis certifical	To Be	25. Was case referred to medical examiner? 1 \(\text{Yes} \) 25 No	ospital: 1 ☐ Inpatient 2 ☐ I	ER/Outpatien	t 3 DOA Othe	r	eath <i>(Check only o</i> Home 5 Resi	heck only one) 5▼ Residence 6 □Other (Specify)		
ending Pl sath. or: After ti	Certification:	27. Manner of Death 1 Natural 5 Pending 2 Accident investigation	28a. Date of Injury (Month, Day Year)	28b. Time of Injury	28c. Injury Work M 1 \(\text{Y}	at ? ′es 2 □ No	28d. escribe	how injury	occurred	
To the Hospital or Attending P within 24 hours after death. To the Funeral Director: After t completely filled in by the funera		3 Suicide 6 Could not be 4 Homicide determined	28e. Place of Injury - At ho building, etc. (Specify	·) 			City or To	wn, State)		ral Route Number,
he Host in 24 hot he Fune pletely fi	edical	(Check only 2 Medical Exemir one)	ician: To the best of my knowner: On the basis of examinat and manner stated.	wledge, death ion and/or inv	vestigation, in my op	inion, death oc	ce, and due to the curred at the time,	date and	place, and due	to the cause(s)
To t To t	Σ	29b. Signature and title of certifier C. Erwert 6	win In w. s.		29c. License	number 63253			e signed (Month	
DA 571		30. Name and address of person who co	mpleted cause of death (Item	23a) (Type, st Marl	Print)					·
Sta Registr		31. Date filed (Month, Day, Year)	32. Registrar's Signal	ure	barkel					

	State of Maryland / Department of Health and Mental Hygiene Certificate of Death Certificate of Death State of Maryland / Department of Health and Mental Hygiene 2009 42994											
Physician/ Medical	1. Decedent's Name (First, Middle, Last) Sarah Elizabeth Willin						2. Date o Month Decem			Day Year		
Examiner		4a. Facility Name (if not institution, give street and number)		Centu	/		Town, or Location of Death			County of Deat	h.	
Funeral Director	5. Social Secur		6. Sex 1 ☐ M 2 🔀	7. Age (In yrs. last	<i>birthday)</i> Yrs.	If Under 1 Year Months Days	If Under 24 Hr. Hours Mir		th ay, Year)	g Rin	thplace (State or Foreign untry) Laware
f show dat		10b. County		1	I0c. City, To	own or Loc	eation					10d. Inside City Limits
r 28a-1 notifie	MD 10e. Street and		omico		De	lmar	10f. Zip Code			40.00		1 X Yes 2 □ No
leath with the Maryland tems 23a or 28a-f shoer must be notified at Funeral Director	6 W.	Chestnut	Street				21875				tizen of What Co	untry?
by by	1 Never	tus Married 2 Marr red 4 Divorced	ried Armed			If	Vas Decedent of His Yes, specify Cuban ☐ Yes 2 🔀 No	, Mexican, Puer	Specify Yes or No- rto Rican, etc.)		14. Race - Ame Black, White Specify:	
ithin 72 hours at lene. r than "natural" the Medical Exc	o Ea tridov	a source so	nt's Education	or Dates. eted)	1	(Give k	ent's Usual Occupa ind of work done du	tion uring most of wo	orking	16b. K	ind of Business	
Hygiene. Other than ent, the M Be Corr		/Seconday (0-12)		ge (1-4 or 5+)			NOT use retired) maker				Home	
be filed ental H rked ot ic even To B		me (First, Middle, L s Banks	ast)						ame (First, Middle, Gibson	Maiden	Surname)	
should and M is mar aumat		's Name/Relationsh	nip (Type, Print) (person	121	-	19b. Mailin	g Address (Street ar			er, City or	Town, State, Zip	Code)
l and 2 Health Item 27 other to	Wayne 20a. Method o	Mathis_	repres				Chestnut	St. D	Date Date		21875 ocation - City or	Town State
. Page 1 iment of tant: If i	1 🗌 Buria 4 🔲 Dona	l 2 🔀 Cremation ation 5 🗌 Other (S	3 🗌 Removal f pecify)		ceme	etery, crem	of Delman	1			,	
Departition Depart	21. Signature	of Funeral Service L	icensee				Name and Address hort Fune		13 Ea ne Delma		Frove St E 1994	
Physician/	23a. Part 1. El ter th. disease, or complicitio is that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate											
Medical Examiner	shock, or near failure. List the accause on each line. Immediate Cause (Final disease or condition resulting in death) Aurung Connot Conformation (Onset and Death Due to (or as a consequence of): Sequentially list conditions, b. Due to (or as a consequence of): Due to (or as a consequence of): Due to (or as a consequence of):											
xecuted n and al-transit Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or linjury											
be execut sician and burial-trar cal Exa	that initiated events c. — Due to (or as a consequen											
tificate be ey ng physician as the buria	IF FEMALE:		d			-						
To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director, After this certificate has been signed by the attending physician and completed filled in by the funeral director, page 2 should be detached for use as the burial-transit Medical Certificate: To Be Completed by Physician/Medical Exami	23b. Was dece	t 12 months? 2 No	1 U L	, outcome of Live Birth 2 Pregnant at ti Jnknown		eath 3 🖳	Ectopic pregnancy Other (specify)				23d. Date of del Month	ivery Day Year
requires that the peen signed by should be deta	23e. Did tobacco use contrib											
The law requires sate has been signate has been signage 2 should to Completed			,,						24a. Was autor perfo	osy ormed?	prior to death?	opsy findings available completion of cause of
certific irector,	25. Was case r examiner? 1 \sum Yes	eferred to medical	Hospital:	\	. a \Box ===	(O 1 - 1 : 1	L ONL	ce of Death (Che				
iding Physi th. After this o funeral dire cate: To	27. Manner of 1 Natura 2 Accide	Death	28a. D	IX Inpatient Pate of injury Month, Day, Y	28	o. Time of injury	28c. Injury : work?	at	Home 5 Resident Resid			fy)
or Attending P s after death. I Director: After t d in by the funera	3 Suicio 4 Homio	e 6 🗆 Could i	not be 28e. Pl	lace of Injury uilding, etc. (et and Number or Rural Route Number, State)		
To the Hospital or Attending Physician: The law within 24 hours after death. To the Funeral Director. After this certificate has completed filled in by the funeral director, page 2 s. Medical Certificate: To Be Comp	29a. Certifier (Check only one)	2 L Medical E	xaminer: On the	basis of exar	mination an	d/or investi	ocured at the time, ogation, in my opinion eath occurred at the	, death occurred	d at the time, date a	ind place,	, and due to the c	ause(s) and manner stated.
vith vith com	29b. Signature	and title of certifier	onue-	0	40		29c. License	number			te signed (Month	, Day, Year)
gr	mail	address of person v	roudu	cause of deat	th (Item 23a	11/40	int)		SALIS		3/09 in and	21804
State Registrar	31. Date filed (I	OEC 29	2009	2. Registrar's	Signature	1. 1	and	,	•			

Baltimore, Maryland 21215-0036

Division of Vital Records, P.O. Box 68760

Baltimore, Maryland 21215-0036 Box 68760 P.0.

Records,

Division of Vital

Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Vernon Franklin Wagner Month 2/21 Medical 4a. Facility Name (if not institution, give street and number Examiner 4b. City, Town, or Location of Death 4c. County of Death Contor If Under 1 Year Days ninsula Regional Medical 8. Date of Birth (Month, Day, Year) May 13, 1935 7. Age (In yrs. last birthday, **Funeral** 9. Birthplace (State or Foreign 1 M 2 □ F Maryland Director 214-32-6337 Yrs Usual Residence of Decedent "natural", or items 23a or 28a-f show edical Examiner must be notified at 10a. State death with the Maryland 10b. County 10c, City, Town or Location 10d. Inside City Limits Director MD Worcester Salisbury 1 Yes 2 K No 10e. Street and Number 10f. Zip Code 10g, Citizen of What Country? Funeral U.S.A. 21804 2241 St. Lukes Road 13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Black, White, etc. ş 1 Never Married 2 Married within 72 hours after 1 ☐ Yes 2 No Specify: Completed 3 X Widowed 4 □ Divorced 1959 white Year or Dates the Medical 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) ייים Mental Hygiene. ז 27 is marked other than "n r traumatic event" יי Elementary/Seconday (0-12) College (1-4 or 5+) Plumbing Plumber Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) permit. Page 1 and 2 should be file Department of Health and Mental I Important: If item 27 is marked o ည Nellie Denston Albert Rollins Wagner 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 2241 St. Lukes Road Salisbury, MD 21804 Brian Dale Wagner 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place, 20c. Location - City or Town, State Date 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State Important: If any injury or once. Dec. 29, 2009 Salisbury, Maryland 4 ☐ Donation 5 ☐ Other (Specify) Family Cem. 21. Signature of Funeral Service Licensee 22. Name and Address of Facilit 13 East Grove Street Short Funeral Home Lwel 19940 Delmar. DE 23a. Part 1. Enter the disease complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate shock, or heart failure. List only Interval Between Immediate Cause (Final Onset and Death Physician/ oronary disease or condition resulting in death) Medical Examiner ardiemnipa Sequentially list conditions Examine if any, leading to immediate cause. Enter Underlying Due to (or as a consequence of) Cause (Disease or linjury and that initiated events resulting in death) Last Due to (or as a consequence of): attending physician Physician/Medical The law requires that the death certificate be as the IF FEMALE: nse yes, outcome of pregnancy
Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 🗌 Ectopic pregnancy ō in the past 12 months?
1 ☐ Yes 2 ☐ No Pregnant at time of death 5 Other (specify) Month Day Year the should be detached à Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 Yes 2 No 3 Probably 4 Unknown Be Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has autopsy performed? Yes 2 2 🗌 No ours after death.

eral Director: After this certific filled in by the funeral director, or Attending Physician: 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Hospital. 1 🗌 Yes Other: ည 1 Inpatient 2 KER/Outpatient 3 I 4 Nursing Home 5 Residence 6 Other (Specify) 28a. Date of injury (Month, Day, Year) Manner of Death Certificate: 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1_Natural 5 Pending 1 Yes 2 No Ascident Investigation Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined 24 hours Funeral Medical ertifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a Certifier completed (Check To the within 2 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) -LIVA South State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Zeiler Judith Nancy Month 2075PM Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death 34/15bur TENINSULA 100mic If Under 1 Year | If Under 24 Hrs. 6. Sex 8. Date of Birth Funeral 9. Birthplace (State or Foreign 1 □ M 2 🎛 F Days 214-50-2862 59 Months 04/14/1950 Maryland Director Usual Residence of Decedent Page 1 and 2 should be filed within 72 hours after death with the Maryland ment of Health and Mental Hygiene.

Int. If item 27 is marked other than "natural", or items 23a or 28a-f shoury or other traumatic event, the Medical Examiner must be notified at 10c. City, Town or Location 10d. Inside City Limits Director Maryland Wicomico Hebron 1 Yes 2 XNo 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 7689 Levin Dashiell Road 21830 USA 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Armed Forces Completed by 1 Never Married 2 Married 1 ☐ Yes If Yes, Give 2 X No Maryland 21215-0036 1 ☐ Yes 2 X No Specify: white Specify: 3 X Widowed 4 Divorced Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) housewife domestic Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ဂ္ Lillie Curtin Charles Holobinko 19a. Informant's Name/Relationship (Type, Print) 9b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code, 7689 Levin Dashiell Rd., Hebron, MD 21830 Lillie Glenn/daughter Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State cemetery, crematory or other place)
Salisbury Crematory Department of 1 ☐ Burial 2 X Cremation 3 ☐ Removal from State Salisbury, MD 12/29/09 4 Donation 5 Other (Specify) Important any interest Holloway Funeral Home Professional Association Snow Hill Rd., Salisbury, MD 21804 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ disease or condition Dreumonia Medical resulting in death) Due to (or as a consequence of) **Examine** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury that initiated events Examiner Due to (or as a consequence of) To the Hospital or Attending Physician: The law equires that the death certificate be executed within 24 hours after cleath.

To the Funeral Director: After this certifica e has i een signed by the attending physician and completed filled in by the funeral director, page 2 should be detached for use as the burial-transit Due to (or as a consequence of) resulting in death) Last Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death
4 Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 🔲 Ectopic pregnancy in the past 12 months? Month Year 5 Other (specify) 1 Yes 2 No 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 3 ☑ Probably 4 ☐ Unknown 2 🗌 No 24b. Were autopsy findings available prior to completion of cause of 24a. Was an autopsy perform 1 ☐ Yes 2 ☐ No 25. Was case referred/to medical Certificate: To Be 26. Place of Death (Check only one) examiner? ER/Outpatient 3 DOA 1 🗐 Inpatient 2 🗌 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 27. Manuer of Death 28c. Injury at 28a. Date of injury 28b. Time of 28d. Describe how injury occurred (Month, Day, Year) 1 Matural 5 Pending work' 1 Tes 2 No Investigation 6 Could not be Accident Sulcide 3 ☐ Sulcide 4 ☐ Homicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

☐ Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. only one) 3

State Registrar 29b. Signature

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

egistrar's Signatı

29c, License number

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene 2000

Laverne Allen		State of Maryland / Department For State Certificate			2009	42991				
Physician	/	Registrar 1. Decedent's Name (First, Middle,Last)		2. Date of Death		3. Time of Death				
Medical Examine		Laverne Allen	10.07	Month December		1310 hrs				
C.A.		4a. Facility Name (if not institution, give street and number) 1006 Stoddard Court	4b. City, Town, or Location of Death Baltimore		4c. County of Death					
Funeral	٦	5. Social Security Number 6. Sex 7. Age (In yrs. last birthday	·	. 8. Date of Birth	(MM/DD/YYYY) 9. Birth Foreign					
Director	2	217-56-6675 1 M 2 XF 57	Yrs. Months Days Hours Min.	April		ntry) Ma.				
ny	-	Usual Residence of Decedent 10a. State 10b. County 1 10c. City, Town or Location								
nd show s	_	Md. NA Balt	imore-			1 Yes 2 No				
Maryla 28a-f d at or	3	10e. Street and Number	10f. Zip Code	10	g. Citizen of What Count	try?				
r death with the Maryland or items 23a or 28a-f sh	<u>=</u>	1006 Stoadard Ct.	2/201	anifo Van an No	USF	as Indian Black				
eath w		11. Marital Status 1 Never Married 2 Married 12. Was Decedent Ever in U.S. Armed Forces? 1 Yes 2 No	. Was Decedent of Hispanic Origin? (Sp. If Yes, specify Cuban, Mexican, Puerto		14. Race - Americ White, etc.	an indian, black,				
after d	5	3 Widowed 4 Divorced of Pales:	Yes 2 No specify:		Specify: B	ack				
hours "natur			edent's Usual Occupation (Give kind of v ng most of working life. DO NOT use reti		16b. Kind of Business/In	dustry				
thin 72 than than ledical	Completed	Committee (Control of Control of	Disabled		NL	4				
5-06 filed wi Hygier flother the M		17. Father's Name (First, Middle, Last)	18.Mother's Name	(First, Middle, Ma	aiden Surname)					
ID 21215-0036 should be filed within 7 should be filed within 7 is and Mental Hygiene 7 is marked other than natic event, the Medical To Be Comple	o li	19a. Informant's Name/Relationship (Type, Print 19b. Mi	ailing Address (Street and Number or F	VIDIO tural Route Numb	per, City or Town, State,	SON Zip Code)				
O & 5	Ī	Mr. Bruce Allen 134	14 HOPKins A	ve Bo	alto. Md	.21227				
s l and of Heal			sposition (Name of cemetery, or other place)	/	20c. Location - City or T	own, State				
Baltimore, permit. Pages I ar Department of Hes Important: If ite Important: If ite Injury or other tr		4 Donation 5 Other Specify:	Crematory 113	2010	Balto.	Md.				
Baltimore, ME permit. Pages 1 and 2 be permit. Pages 1 and 2 be perturent of Health at Important: or other trauminjury or other trauminjury or other trauming.	4	21. Signature of Funeral Service License	22. Name and Address of acility	Funera	y Home P.	A.				
Physician	Ť	23a. Part I. Enter the disease, or complications that caused the death. Do not en failure. List only one cause on each line.	ter the mode of dying, such as cardiac or	respiratory arres	st, shock, or heart	Approximate Interval Between Onset and				
xaminer	1	Immediate Cause (Final disease a. Morphine intoxicat:	ion		:	Death				
	1	or condition resulting in death) Due to (or as a consequence of):								
	<u> </u>	Sequentially list conditions, if any, leading to immediate Due to (or as a consequence of): cause. Enter Underlying Cause								
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Records, The law require. ficate has been signage 2 should be				24a. Was ar autopsy perform	y prior to co	opsy findings available impletion of cause of				
ital Recition: The last certificate last rector, page	3		OC Plant (Partle (Obs.)	1 Y Yes 2		2 No				
Vital ysician: his certi director	Ď	25. Was case referred to medical examiner? 1 ✓ Yes 2 No Hospital: 1 Inpatient 2 ER/Outpat	26.Place of Death (Check of tient 3 DOA Other Nursin		tesidence 6 🗸 Other:	Scene				
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Hospit 24 hour Funer tely fill		4 Homicide 22a Certifier 1 Certifying Physician: To the best of my knowledge, death of								
Division of Vital Records, P.O. Box 68760, To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the bunal - transicial Certification: To Be Completed by Diversizian/Medical Ex		one) 2 Medical Examiner: On the basis of examination and/or inves and manner stated								
A	≦	29b. Signature and title of certifier	29c. License number O.C.M.E.		29d. Date signed (Mont December 24, 200					
	-	30. Name and address of person who completed cause of death (Item 23a)	0.0							
			111 Penn Street, Baltimore, MI	21201						
Stat	е	31. Date filed (Month, Day, Year) 32. Registrar's Signature	1							

ORIGINAL

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Day Month Year **Physician** 154 ELEANDR み /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner MONTCOMER If Under 1 Year If Under 24 H/s. | 8 Date NURSING HOME Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** Days 1 □ M 2 🛂 F 205-18-7034 Director Maryland 2-20-12 Usual Residence of Deceden 10c. City, Town or Location 10d. Inside City Limits 10b. County a or 28a-f show be notified at 1 ⊈Yes 2 No MD Director 10g. Citizen of What Country? 10e. Street and Number U54 permit. Pages 1 and 2 should be filed within 72 hours after death w Department of Heatth and Mental Hygiene. Important; If item 27 is marked other than "natural", or items 23a any Injury or other traumatic event, the Medical Examiner must to 20860 17310 Funeral 14. Race - American Indian. 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11 Marital Status Black, White, etc. 1 ☐ Yes 2 Mo If Yes, Give Year or Dates: 1 ☐ Never Married 2 ☐ Married 1 ☐ Yes 2 🗷 No Specify: WHITE þ 3. Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) 12 College (1-4or 5+) education TEACHTER 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Carl Gaines Eleanor Yellott ျှ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 17401 Norwood Road Sandy Spring, MD 20860 Friends Nursing Home 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 Donation 5 ☐ Other (Specify) 21. Signature el huneral Santice sicensee State and Andres of Facility oard 655 W. Baltimore Street Director Baltimore, MD 21201 23a. Part1 Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Caus Hinal disease or condition resulting in death) YTHAR PULMONTRUS HYPERTEUNION Due to (or as a consequence of): Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examine Due to (or as a consequence of): Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 □Ectopic pregnancy Month Day Year in the past 12 months? 4□Pregnant at time of death 5 ☐ Other (specify) ☐Yes 2 No 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. à 1 ☐ Yes 2 Mo 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 □ Yes 2 No 24a. Was an performed 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Be Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 Yes 2 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: 5 Pending investigation 1 XNatural 1 ☐ Yes 2 ☐ No

Physician /Medical Examiner be executed

show

Maryland 21215-0036

Baltimore,

Box 68760,

P.0.

Records,

Division or Vital

death.

burial-trar physician as the attending use for signed by the a page 2

After To the Hospital or Attendi within 24 hours after death. To the Funeral Director: A completely filled in by the

2 Accident

3 Suicide 4 ☐ Homicide

29a. Certifier

6 ☐ Could not be

1 🔀 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify)

Romo

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29b. Signature and title of certifier

29c. License number

TEN DAKS

29d. Date signed (Month, Day, Year)

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

State Registrar

Medical

31. Date filed (Month, Day, Year)

JAN 1 2 2010

m 32. Registrar's

	,		t of Health and Me e of Death	ental Hygier	711114	42999
Physicia /Medic		1. Decedent's Name (First, Middle, Last)		2. Date of Death Month	Pay Year 8 2009	3. Time of Death
Examin Funeral		Holy Cross Hospital 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) If Under Months	Town, or Location of Death Spr. 061 1 Year If Under 24 Hrs. Days Hours Min.	4	c. County of Death	
Director		Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location	3 31	1 m m	, 67	USA
he Maryla 28a-f sho	Director	MD Montgomery Silver S	oring MI)		10d. Inside City Limits 12 Yes 2 □ No
s 23a or	eral Dir		20910-534	5	Citizen of What Cou	•
5-UU36 72 hours after death with the Maryland natural", or items 23a or 28a-f show dical Exemitive must be notified at	d by Funeral	11. Marital Status 1	lent of Hispanic Origin? (Specify Cuban, Mexican, Puerto R	cify Yes or No- lican, etc.)	14. Race - Amer Black, White, Specify: B	
within ene.	Completed	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+)	al Occupation k done during most of working e retired) Fant	g 16b.	Kind of Business/Ir	
Maryiand 2 2 should be filed and Mental Hygi is marked other raumatic event,	To Be (17. Father's Name (First, Middle, Last) Noro Deen Sankoh-Villah		atta	Contet	
ballimore, Marylar permit. Pages 1 and 2 should be Department of Health and Ments Important: If iten 27 is marked any Injury or other traumatic er			(Street and Number or Rural STEST (SLE) Rd ne of her place) Da	Silve	Spr. Ng. Location - City or T	MD 20910
Departit. Departit Importa any Injit			d Address of Facility natomy Board re, MD 21201	655 W. Ba	ltimore S	Street
Physician /Medical Examiner		23a. Park. Enter the disease, or complications that caused the death. Do not enter the mod shoot or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) a. Due to (or as a consequence of):	e of dying, such as cardiac or	respiratory arrest,		Approximate Interval Between Onset and Death
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Physician: The law ruths certificate has be rail director, page 2 shu	e Completed	25. Was case referred to medical	00 Plant I Part	24a. Was an autopsy performed?	prior to co death?	opsy findings available impletion of cause of
Physicia r this cerral direct	m	examiner? 1 Yes 2 No Hospital: 1 Inpatient 2 ER/Outpatient 3 DO		e 5 Residence	. , ,	fy)
To the Hospital or Attending I within 24 hours after death. To the Funeral Director: After completely filled in by the funer	Certification: To	Image: Problem of the problem of t	Work? 1 □Yes 2 □No	Describe how injury occurred 28f. Location (Street and Number or Rural Route Number, City or Town, State)		
the Hospital hin 24 hours the Funeral	Medical C	29a. Certifier (Check only one) 1 Certifying Physician: To the best of my knowledge, death occurred and manner stated.	in my opinion, death occurred	d at the time, date a	nd place, and due t	o the cause(s)
To the Vithing Within To the Company of the Company	Ž	29b. Signature and title of certifies 29c.	License number 00068962	29d. D	ate signed (Month, 282	Day, Year)
Stat		30. Name and address of particle with completed cause of death (Item 23a) (Type, Print) 31. Date filed (Month, Day, Year) 32. Registrar's Signature	STE 525 St Gkn Rd, S	lver Spr	ing, MI	20910
Registra	-	JAN 1 2 2010 Sente S. Jak				

Charles crowder 09-10148 Pleas

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible

JNK UNK		1- For State	ate of Maryla		rtment of tificate of	Health ar	nd Mental	Hygiene	200	0 1.2001	
Physic	ian/	Registrar 1. Decedent's Name (First, Midd	le,Last)			Dodin		2. Date of Dea		3. Time of Death	
Vledical Exam		enalies 1. Clowdel						Month Decembe	Month Day Year December 28, 2009		
		4a. Facility Name (if not institution 2539 Aisquith Street	on, give street and no	umber)	4	lb. City, Town, o Baltimore	Location of D	eath	4c. County of Deat	n/a	
Funeral		5. Social Security Number	6. Sex	7, Age (In yrs. la	st birthday)	If Under 1 Yea			th(MM/DD/YYYY) 9. Bi	rthplace (State or	
Director		213-62-5940 Usual Residence of Decedent	1 X M 2 F		56 Yrs.	Months Day	s Hours	Min. Aug.	31,1953 Forei	ountry) N.C.	
any		10a. State 10b. County		10c. City, 1	Town or Location	on				10d. Inside City Limits	
Maryland 28a-f show d at once,	5		ı/a		Baltin	nore				1 X Yes 2 No	
Mary r 28a- ed at	Director	10e. Street and Number	_			10f. Zip Code		1	0g. Citizen of What Cou	ntry?	
with the Maryland ns 23a or 28a-f sho be notified at once	a D	2622 Cecil		cedent Ever in U.S	140 146	212			USA		
eath w items ust be	Funeral	1 Never Married 2 M	arried Armed F			es, specify Cuba	spanic Origin? n, Mexican, Pu	(Specify Yes or No erto Rican, etc.)	- 14. Race - Amer White, etc.	ican Indian, 8lack,	
after d al", or	J. J.		orced If Yes, Give Yes or Dates:	ar	1	Yes 2 X No	specify:		Specify: Bl	ack	
hours natura		15. Decedent's Education (Spe	cify only highest grad			's Usual Occupa			16b. Kind of 8usiness/		
36 nin 72 han " disal 1	pet	Elementary/Secondary (0-12) 12th	College (1	1/2		Labor			Superior and Pad		
21215-0036 nuld be filed within 7 Mental Hygiene. marked other than c event, the Medisa	Completed	17. Father's Name (First, Middle,		-/-				ame (First, Middle, M			
215 be file nital H rked of ent, til	Be (Thomas	Crowde	c				Theadus	Allen		
D 21215-0036 should be filed within 72 hours after death with the Maryland and Mental Hygiene. 7 is marked other than "natural", or items 23a or 28a-f she natic event, the Medical Examiner must be notified at once	ပ	19a. Informant's Name/Relations		- M - L h			et and Number	or Rural Route Num	ber, City or Town, State		
Z d d Z m d Z m m Z m m Z m m Z m m Z m m Z m m Z m m Z m m Z m m Z m m Z m m Z m m Z m m Z m m Z m m Z m m z m m Z m m z m z		Lucy L. Crow 20a. Method of Disposition	der/ster	•		ion (Name of ce	AVE.	Baltimo	ore, Mary.	land 21218 Town State	
Baltimore, permit. Pages I ar Department of Hee Important: If ite		1 Burial 2 X Cremation	K —	om State cr	ematory or other	er place)	1		0 Balto.		
altin mit. P partme portan	i K	4 Donation 5 Other Sp 21 Signature of Funeral Service	ecify: License	1020	22. Na	me and Address	of Facility				
B P D III	g (i	(2)	Mon			HYIH.E	PREST	UGGS FUN ON ST. H	NERAL HOMI BALTO. MD	E 21213	
Physician /M	, 	23a. Part I. Enter the disease, or failure. List only one cause	complications that co on each line.	aused the death. [Oo not enter the	e mode of dying,	such as cardia	ic or respiratory arre	est, shock, or heart	Approximate Interval Between Onset and	
Examiner		Immediate Cause (Final disease or condition resulting in death)								Death	
	or condition resulting in death) Due to (or as a consequence of): b. Chronic Alcoholism										
	ner	if any, leading to immediate cause. Enter Underlying Cause	Due to (or as a	consequence of):							
	Examiner	(Disease or injury that initiated events resulting in death) Last	c. Due to (or as a	consequence of):							
e executed cian and rial - transit	dical E	[] IMPENDED	d								
50, te be exergivesician	ledic	UNPENDED IF FEMALE:	AMENDED 332 If year						T		
cath certificate be attending physic for use as the bur	an/N	23b. Was decedent pregnant in the past 12 months?	e 1 Live bi		· —	ll death 3 [Ectopic pre	gnancy	23d Date of delivery Month D	ay Year	
Division of Vital Records, P.O. Box 68760, Hospital or Attending Physician: The law requires that the death certificate be 24 hours after death. Funeral Director: After this certificate has been signed by the attending physicially filled in by the funeral director, page 2 should be detached for use as the buritely filled in by the funeral director, page 2 should be detached for use as the burit	Physician/Me	1 Yes 2 No 9 Unk	nown 9 Unkno	ant at time of wn	5 Othe	er (Specify)				(1)	
P.O. Es that the caned by the detached		Part II. Other significant conditi		_	ulting in the un	derlying cause g	iven in Part I.	23e. Did tol	pacco use contribute to	he cause of death?	
S, P.(irres than signed d be det	ed by							1 Yes	2 No 3 Prob	ably 4 Unknown	
of Vital Records, ng Physician: The law require the this certificate has been si meral director, page 2 should b	ompleted							24a. Was a autops	y prior to o	opsy findings available ompletion of cause of	
Rec The la icate h	Som							perforr 1 ✓ Yes 2	med? death? □ No 1 ✓ Ye	s 2 No	
tal Recionant The certificate	å	25. Was case referred to medical examiner?	Hospital:				of Death (Cheo				
of Vi ing Phys After this	P.	1 Yes 2 No 27. Manner of Death	28a. Date of (Month,		R/Outpatient 8b. Time of Inju		y at Work?	-	Residence 6 Other	Scene	
ion (tending eath.	텵	1 Natural 5 Pendi	ng	Day, Year)			es 2 No		on injury occurred		
Division tal or Attendi rs after death. al Director: A	ifica		not be 28e. Place	of Injury - At hom	ne, farm, street,	factory, office be	uilding, etc.		reet and Number or Run	al Route Number, City	
Divisior Hospital or Attence 24 hours after death Funeral Directors tely filled in by the	Certification:	4 Homicide determ	nined (Specify)					or Town, Sta	ate)		
29a. Certifier (Check-only) 1 29a. Certifier (Check-only) 2 29a. Certifier (Check-only) 2 29a. Certifier (Check-only) 2 29a. Certifier (Check-only) 3 29a. Certifier (Check-only) 4 29a. Certifier (Check-only) 4 29a. Certifier (Check-only) 5 29a. Certifier (Check-only) 6 29a. Certifier (Check-only) 7 29a. Certifier (Check-only) 8 29a. Certifier (Check-only) 1 29a. C											
To the within 2 To the complet	Med	29b. Signature and title of ceryfier	and manner st	ated.		29c. License			29d Date signed (Mon		
		(Kanto	len			0.0.1	I.E.		December 29, 20		
21		30. Name and address of person v			,		0.00		-		
		Laron Locke MD. As 31. Date filed (Month, Day, Year)	sistant Medical			Street, Baltim	ore, MD 21	201			
St Regist		JAN 12		gistrar's Signature	bar	les!					

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